Federal Ministry of Health & Social Welfare

JOINT ANNUAL REVIEW

Health Sector Statistical Book (JAR BOOK)

NOVEMBER 2025

FOREWORD

As the Federal Ministry of Health and Social Welfare continues to steer national efforts toward achieving Universal Health Coverage (UHC) and the health-related Sustainable Development Goals (SDGs), reliable statistics are indispensable for tracking progress, identifying gaps, and ensuring accountability in the delivery of quality healthcare services.

The Nigeria Health Statistics Book 2025 represents an important milestone in the country's commitment to strengthening the health system through the implementation of the Nigeria Health Sector Renewal and Investment Initiative (NHSRII). This publication consolidates data from multiple sources – including routine health information systems, population-based surveys, and administrative records – to provide an accurate and holistic picture of the nation's health status and performance.

The 2025 edition highlights key trends across priority areas such as maternal and child health, disease prevention and control, non-communicable diseases, health financing, human resources for health, and service delivery indicators. It serves as both a reference and a policy tool to guide government agencies, development partners, researchers, and health managers in formulating evidence-driven interventions that address the most pressing health needs of Nigerians.

This achievement is the outcome of collaborative efforts between the Federal Ministry of Health and Social Welfare, its agencies and parastatals, State Ministries of Health and their agencies, as well as our partners. I commend the DHPRS team and all stakeholders who contributed their expertise and commitment to ensuring the accuracy, completeness, and relevance of this publication.
It is my sincere hope that this Nigeria Health Statistics 2025 will not only enhance understanding of our health landscape but also stimulate renewed commitment toward improving the health and well-being of all Nigerians through data-informed policies and programs.

Muhammad Ali Pate CON
Honourable Minister of Health and Social Welfare
Federal Republic of Nigeria
November 2025.

PREFACE

The administration of President Bola Ahmed Tinubu (GCFR) is committed to improving the health of Nigerians by ensuring that policy and planning for Nigeria's health sector are grounded in accurate, timely, and actionable data. The Nigeria Health Statistics 2025 embodies this commitment and stands as evidence of our resolve to institutionalize evidence-based decision-making, transparency, and accountability in the delivery of quality healthcare services.

Through the Renewed Hope Agenda, this administration is committed to implementing it's 9-point agenda to significantly transform the health of Nigerians namely Health Sector Governance and Leadership for the Achievement of UHC, Equity and Quality, PHC as the Bedrock of the Health System, Emphasis on Preventive Healthcare, Improve Allocation of Healthcare and Expanded Health Insurance, Public Health Emergency Readiness, Local Research Improvement, Better Emphasis on Mental Health and Drug Abuse and Job Creation with Better Welfare for Health workers.
This publication is one of how the government and the FMOH hold itself accountable to the agenda and it is a scorecard of how far we have gone to ensure that the promise of this administration is fulfilled to the people of Nigeria.

As we continue implementing the Nigeria Health Sector Renewal Investment Initiative (NHSRII), the data and indicators presented here will serve as critical data-points for guiding investments, measuring outcomes, and ensuring that resources are aligned with the nation's priorities. I trust that the insights from the Nigeria Health Statistics 2025 will serve as a guide for decision-makers, development partners, and all stakeholders to inform policy directions, strengthen accountability, and advance our collective pursuit of a healthier and more equitable Nigeria.

I commend the Department of Health Planning, Research and Statistics, other departments in the Ministry, SWAp Coordination Office and all collaborating MDAs for their diligence and dedication in producing this edition. Together, we reaffirm our shared vision of a health sector that is data-driven, people-centered, and capable of delivering improved health and well-being for every Nigerian.

Dr. Iziaq Adekunle Salako,
Honourable Minister of State for Health,
Federal Ministry of Health and Social Welfare
Abuja, Nigeria
November 2025

ACKNOWLEDGEMENT

The **Nigeria Health Statistics 2025** or Joint Annual Review (JAR) Book 2025 provides a comprehensive and evidence-based overview of the performance of Nigeria's health sector across key thematic areas. As part of our mandate within the Department of Health Planning, Research and Statistics (DHPRS) of the Federal Ministry of Health and Social Welfare, this publication serves to strengthen the national health information system and ensure that data remains the foundation for planning, policy formulation, monitoring, and evaluation.

The compilation of this report reflects the collective effort of dedicated professionals and institutions committed to the generation, validation, and use of quality health data. Drawing on routine data from the National Health Management Information System (NHMIS), national surveys, and administrative records, this edition presents the most current and reliable statistics on health outcomes, service coverage, human resources, financing, and disease trends across the federation.
The 2025 edition underscores the Ministry's continued focus on data-driven health system strengthening. By providing accessible, standardized, and validated health information, it supports evidence-based decision-making at federal, state, and local government levels. The publication also aligns with national and global frameworks, including the Nigeria Health Sector Renewal Investment Initiative (NHSRII), the National Health Data Governance Framework, and the Sustainable Development Goals (SDGs) monitoring agenda.

We extend our appreciation to all stakeholders and partners – particularly the National Bureau of Statistics (NBS), the National Population Commission (NPC), development partners, and State ministries of health, all health agencies and parastatals at all levels, service providers, academia and the private sector – for their invaluable collaboration and contributions to this report.
It is our expectation that this publication will continue to serve as a key reference for researchers, policymakers, and development partners in designing interventions and measuring progress toward improved health outcomes for all Nigerians.

Daju Kachollom S. mni,
Permanent Secretary,
Federal Ministry of Health and Social Welfare
Abuja, Nigeria
November 2025

Executive summary

The **Nigeria Health Statistics 2025** or Joint Annual Review (JAR) Book 2025 provides a comprehensive assessment of Nigeria's progress toward achieving Universal Health Coverage (UHC) and the Sustainable Development Goal 3 (SDG 3) health targets. The report is organized into six parts, covering the four pillars of the NHSRII namely sector leadership and governance, service delivery, the health value chain, health security, and the performance of the three key enablers: Data and Digitization, Health Financing, and Culture and Talent Management.

Part 1 highlights country background and progress on UHC and SDG 3 showing that Nigeria has made incremental progress in several health outcomes, including improvements in immunization coverage and reductions in child and maternal mortality. However, overall performance on SDG 3 remains off-track, with low service coverage and inadequate financial protection, signalling the need for stronger health system investments and policy alignment.

Part 2 highlights progress made on pillar I; Leadership and Governance showing improved oversight and accountability, with 75% of Ministerial Oversight Committee meetings held and 60% of NCH resolutions completed. Donor commitment to the Basic Health Care Provision Fund (BHCPF) was fully met, and 90% of States conducted their JARs. Citizen engagement is improving, as 75% of respondents expressed satisfaction with quality of care. However, human resource regulation gaps persist, no certificates of standards were issued to facilities, and only 20% of regulatory bodies have digitized their professional registers.

Part 3 shows that progress on Pillar II – Health Service Delivery remains uneven across the country, with no primary or secondary facilities certified as compliant with national standards for BeMONC and CeMONC after assessment. Maternal health indicators show persistent challenges, 3,689 facility maternal deaths in PHCs and 698 in BHCPF facilities and an increasing burden of Severe Acute Malnutrition. Immunization data reveal discrepancies between administrative (DHIS2) and NDHS data, with administrative coverage consistently higher. While 39% of children aged 12–23 months are fully immunized per NDHS 2024, DHIS2 reports 43%.

This gap raises concerns around data quality and service completion. The RMNCH Scorecard reveals disparities across states, with progress in immunization and malaria control but lagging performance in skilled birth attendance, family planning, and vitamin A supplementation.

Significant progress has been recorded in HIV and TB control, with 90% ART coverage, 96% viral load suppression, and 93% TB treatment success, suggesting readiness for gradual transition into routine services. However, non-communicable diseases (NCDs) continue to rise, with limited-service availability, only 20% of facilities provide NCD or mental health care. Road traffic accidents, malaria, and postpartum haemorrhage remain leading causes of death, compounded by insufficient blood banks (30 registered) and limited ambulance coverage (502 nationwide).

Part 4 shows progress made on Pillar III (Unlocking the Health Value Chain) of the NHSRII. Efforts to strengthen local production yielded modest gains, including 11,754.8 metric tons of Ready-to-Use Therapeutic Food (RUTF) produced domestically and 66 products transitioned to local manufacturing under NAFDAC's 5+5 Policy. However, no vaccine clinical trials were conducted, and local production of malaria nets (LLINs) remains non-existent. Strengthening linkages between regulatory and production entities such as DFDS and PVAC remains a key priority.

Part 5 which is on pillar IV – Health Security, shows that Nigeria recorded ten disease outbreaks in 2025, a decline from previous years reflecting improving epidemic preparedness. Eighty-six percent of States now have functional Public Health Emergency Operations Centers (PHEOCs). Nevertheless, limited human capacity for climate change adaptation continues to weaken health security resilience. While in part 6 reviewed the performance on the Three Enablers: Data and Digitization, Health Financing, and Culture and Talent Management. Performance remains mixed. Fragmented health information systems and low digitization hinder data integration and decision-making. Despite growing donor and domestic resource mobilization, financial protection remains weak, with only 10% of the population covered by health insurance in 2025. Low public awareness and understanding of health insurance further constrain progress toward UHC.

The 2025 JAR book highlights a health system showing gradual but uneven progress, characterized by gains in governance, disease control, and local production of essential medicines and vaccines. It notes that the system is however constrained by gaps in health service quality, workforce availability, data reliability, and financial protection. Strengthening coordination, accountability, and investment across these pillars will be essential to sustain momentum toward Universal Health Coverage and achieving SDGs 3 targets.

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ABBREVIATIONS	
ANC	Antenatal Care
AOP	Annual Operational Plan
ART	Antiretroviral Therapy
ATM	AIDS, Tuberculosis, and Malaria
BEmONC	Basic Emergency Obstetric and Newborn Care
BHCPF	Basic Health Care Provision Fund
BMGF	Bill & Melinda Gates Foundation
BMPHS	Basic Minimum Package of Health Services
CA	Cancer
CAP	Cancer Access Partnership
CEmONC	Comprehensive Emergency Obstetric and New-born Care
CHEW	Community Extension Health Worker
CHF	Cancer Health Management Fund
CHO	Community Health Officer
CM	Case Management
CPR	Contraceptive Prevalence Rate
CRF	Consolidated Revenue Fund
CRVS	Civil registration and vital statistics
CVD	Cardiovascular Disease
DFF	Decentralized Facility Financing
DHIS2	District Health Information System 2
DHS	Demographic and Health Survey
EHR	Electronic Health Records
e-IDSR	Electronic Integrated Disease Surveillance and Response System
EMR	Electronic Medical Record

ABBREVIATIONS	
EMS	Emergency Medical Service
EMT	Emergency Medical Transport
ENT	Ear, Nose and Throat
EOC	Emergency Operational Center
EQA	External Quality Assurance
FASTR	Frequent Assessment and System Tools for Resilience
FCT	Federal Capital Territory
FDAC	Food and Drug Administration and Control
FEC	Federal Executive Council
FGoN	Federal Government of Nigeria
FMC	Federal Medical Centre
FMoH	Federal Ministry of Health
FMOH&SW	Federal Ministry of Health and Social Welfare
FP	Family Planning
FTH	Federal Teaching Hospital
GIFSHIP	Group Individual and Family Social Health Insurance Programme
GON	Government of Nigeria
GOPC	General Out-Patient Clinic
HCW	Health Care Workers
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HMO	Health Maintenance Organization
HRH	Human Resources for Health
HSRII	Health Sector Renewal and Investment Initiative

ABBREVIATIONS	
HSS	Health Systems Strengthening
HSSB	Health Sector Strategic Blueprint
HTS	HIV Counselling and Testing Services
IDSR	Integrated Disease Surveillance and Response
IPC	Infection Prevention and Control
ISS	Integrated Supportive Supervision
ITN	Insecticide-Treated Net
JAR	Joint Annual Review
JCHEW	Junior Community Extension Worker
LGA	Local Government Area
LLINs	Long Lasting Insecticide-Treated Nets
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MAMII	Maternal Mortality Reduction Innovation and Initiatives
MCH	Maternal and Child Health
mCPR	Modern Contraceptive Prevalence Rate
MDAs	Ministries, Departments and Agencies
MNCH	Maternal, Newborn, and Child Health
MOC	Ministerial Oversight Committee
MOU	Memorandum of Understanding
MPDSR	Maternal and Perinatal Death Review and Surveillance
mRDT	Malaria Rapid Diagnostic Tests
NACA	National Agency for the Control of AIDS
NAFDAC	National Agency for Food and Drug Administration and Control
NASCP	National AIDS and STD Control Programme

ABBREVIATIONS	
NBSA	National Blood Service Agency
NCCP	National Cancer Control Programme
NCDC	Nigeria Centre for Disease Control and Prevention
NCDs	Non-Communicable Diseases
NCH	National Council on Health
NDARS	National Data Reporting System
NDHI	Nigerian Digital Health Initiative
NDHS	Nigeria Demographic and Health Survey
NEHP	National Eye Health Programme
NEMSAS	National Emergency Medical Services and Ambulance System
NHA	National Health Accounts
NHAct	National Health Act
NHIA	National Health Insurance Authority
NHLMIS	National Health Logistics Management Information System
NHMIS	National Health Management Information System
NHREC	National Health Research Ethics Committee
NHSRII	Nigeria Health Sector Renewal Investment Initiative
NMEP	National Malaria Elimination Programme
NMR	Neonatal Mortality Rate
NNHS	National Nutrition and Health Survey
NPC	National Population Commission
NPHCDA	National Primary Health Care Development Agency
NTBLCP	National TB and Leprosy Control Programme
NTD	Neglected Tropical Disease
NTLCP	National Tuberculosis and Leprosy Control Programme

ABBREVIATIONS	
OOPE	Out-of-Pocket Health Expenditure
OPM	Oxford Policy Management
P4SC	Programming for Sustainable Capacity
PHC	Primary Health Care
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PPH	Post-Partum Haemorrhage
PPP	Public Private Partnership
QoC	Quality of Care
qPCR	Quantitative Polymerase Chain Reaction
R&D	Research and Development
RMET	Resource Mapping and Expenditure Tracking
RMNCAH+N	Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition
RSSH	Resilient and Sustainable Systems for Health
RUTF	Ready-to-Use Therapeutic Food
SACA	State Agency for the Control of AIDS
SASCP	State AIDS and STD Control Programme
SBA	Skilled Birth Attendance
SMOH	State Ministry of Health
SSHIA	State Health Insurance Agencies
SWAp	Sector-Wide Approach
TBA	Traditional Birth Attendant
VGF	Vulnerable Group Fund
WACP	West African College of Physicians
WHO	World Health Organization

01

Background and Context

Country Profile

Nigeria, is the most populous country in Africa, located in West Africa and spans 923,769 square kilometres. More than 60% of Nigeria's population are youth and under the age of 25.

Figure 1: Map showing States and the various geopolitical zones

Demographics and Key Health Indicators

Estimated Population
237.5m

Annual Growth Rate
2.5%

Total Fertility Rate
4.8

Women of childbearing age
11.8m

Children under 5 years
47.5m

Children under 1 years (infants)
9m

Life Expectancy
55.2yrs

male 54

female 56

According to the National Population Commission, the country's population was estimated to be 237.5 million in 2025 with an unchanging age distribution pattern consisting mostly of children under 5 and a growing youth population. Nigeria's population size is projected to continue increasing over the coming decades despite investments in family planning and reproductive health initiatives. Nigeria remains characterized by high fertility rates. This persistent high fertility is driven by a variety of factors including socioeconomic factors (e.g. widespread poverty and low levels of educational attainment, particularly among women, contribute significantly to the country's high fertility rate), cultural norms (e.g. early marriage for girls and a strong desire among families to have many children), low adoption of modern contraception and high under-5 mortality rates.

Given the current high fertility rates, which show little sign of significant decline in the immediate future, Nigeria's population is expected to exceed 400 million by 2050. Such growth will make Nigeria the third most populous country in the world.

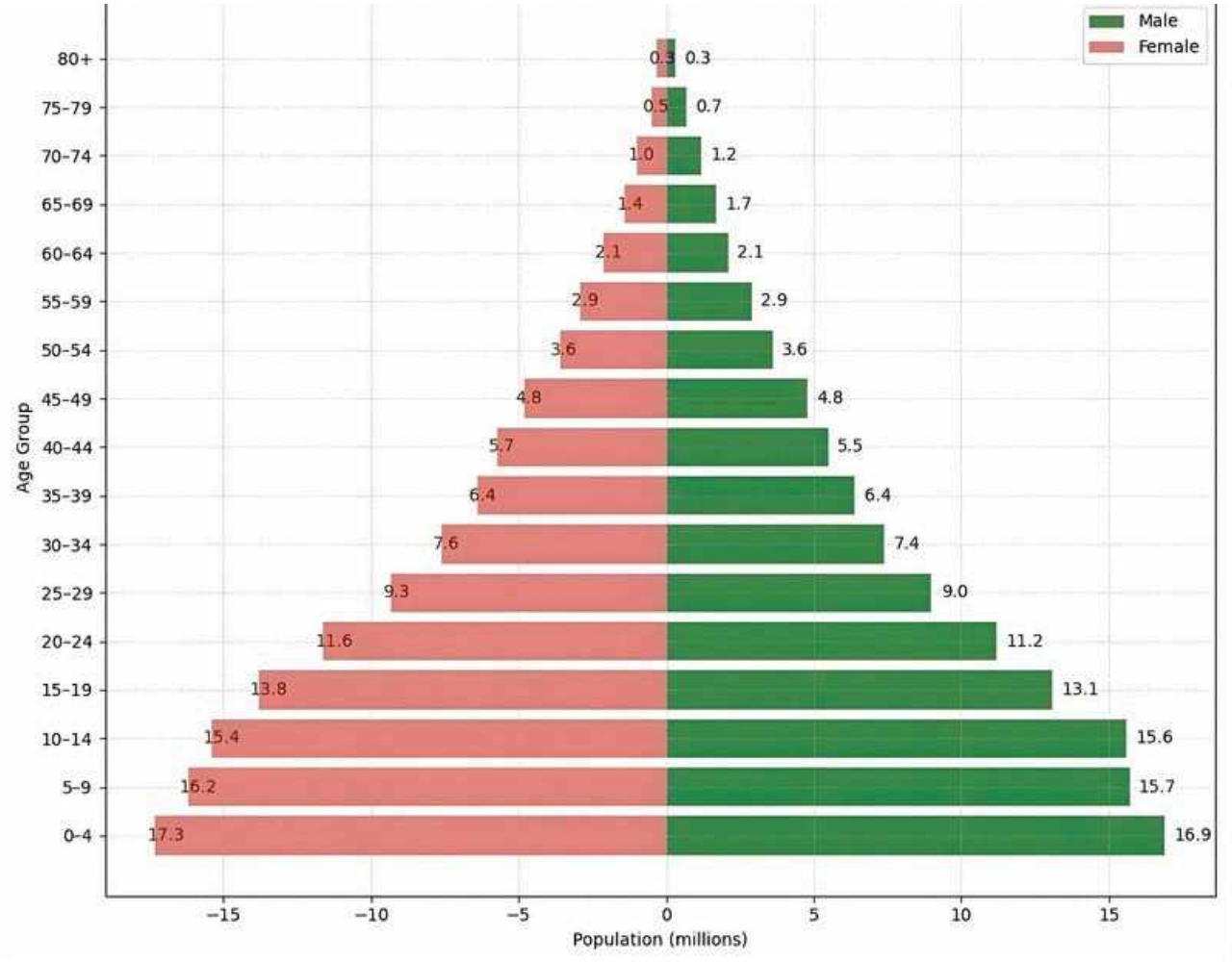


Figure 2: Population by Age and Gender

Figure 3: Population Density across States (2025 NPC estimates)

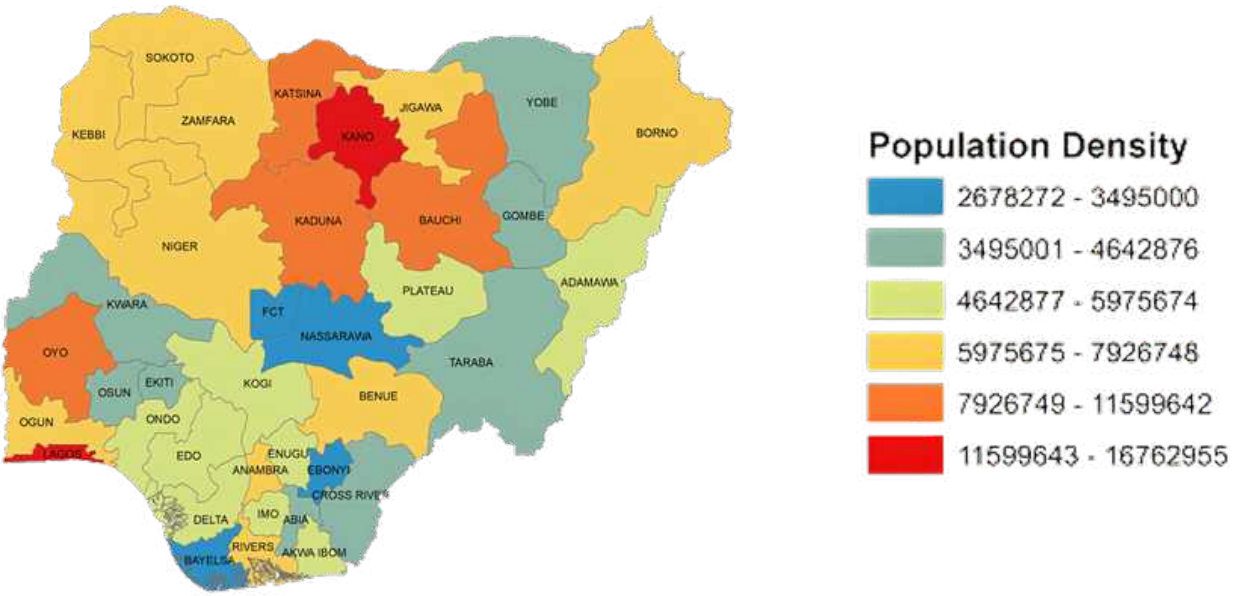


Figure 4: Total fertility rate 15-49 years trend (NDHS 1990-2024)

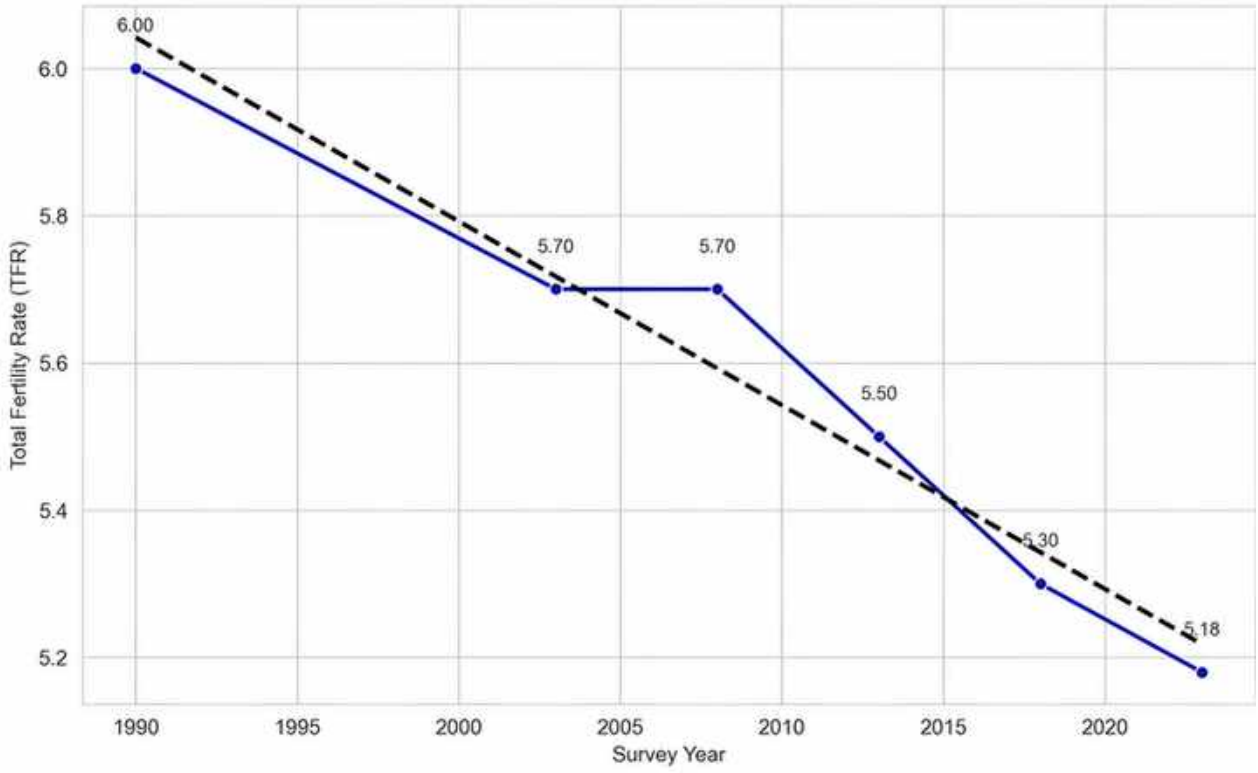
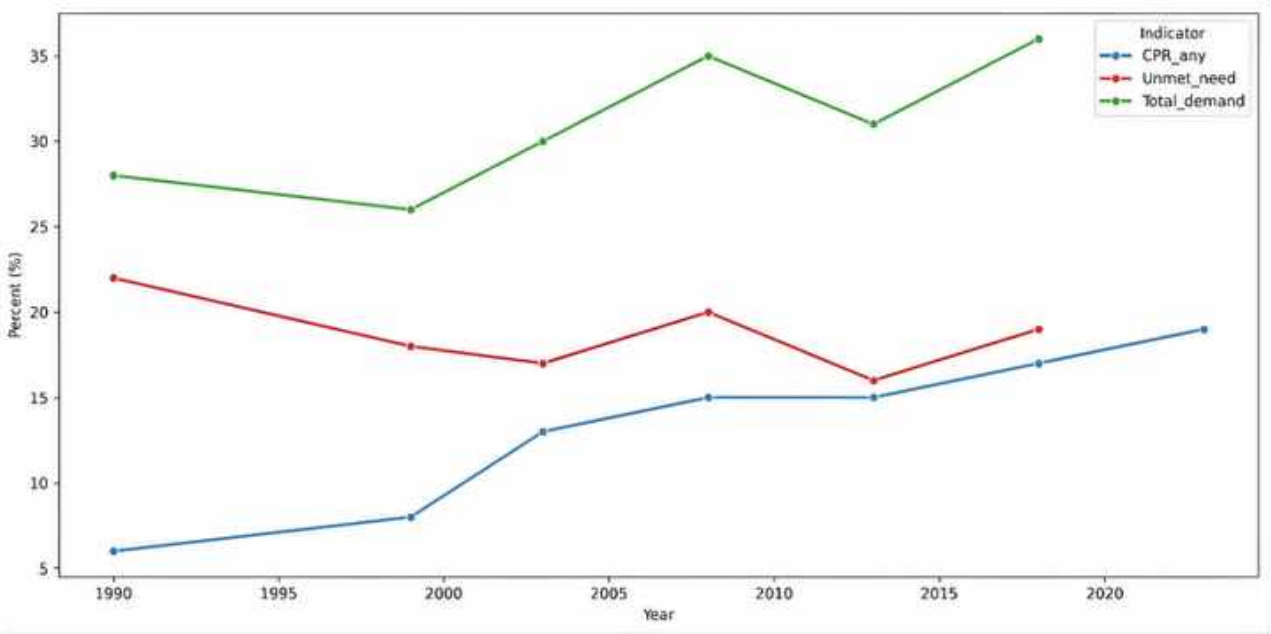


Figure 5

Trend in the use of, need for and demand for family planning of women 15-49 years (NDHS 1990-2024)



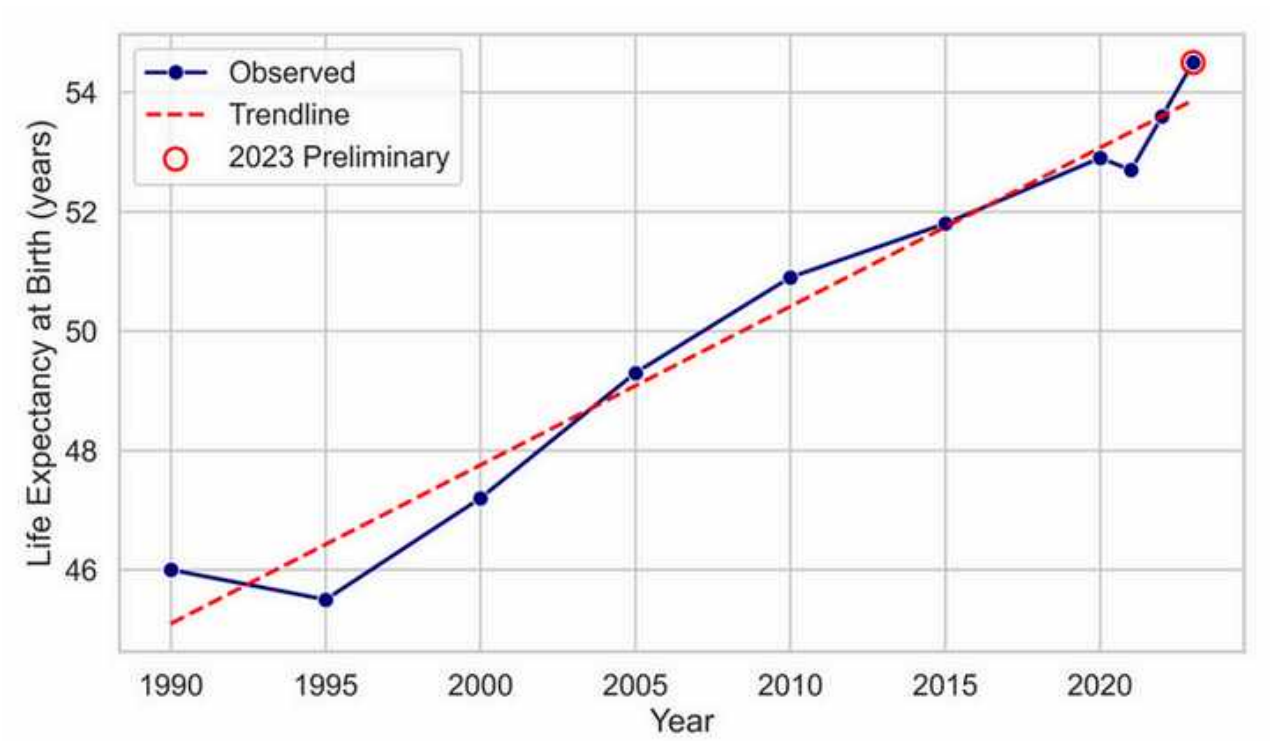


Figure 6: Life expectancy at birth in Nigeria

Figure 7: Trend in Under-5 Mortality (NDHS 1990-2024)

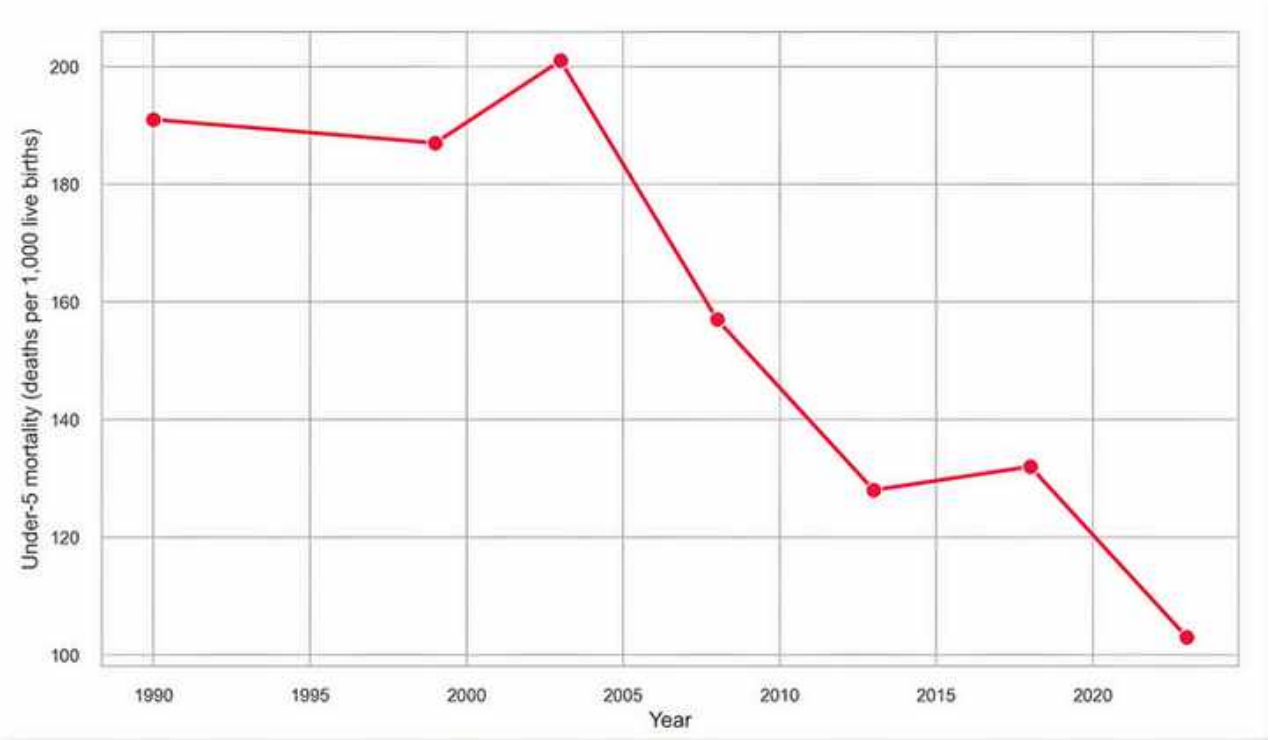
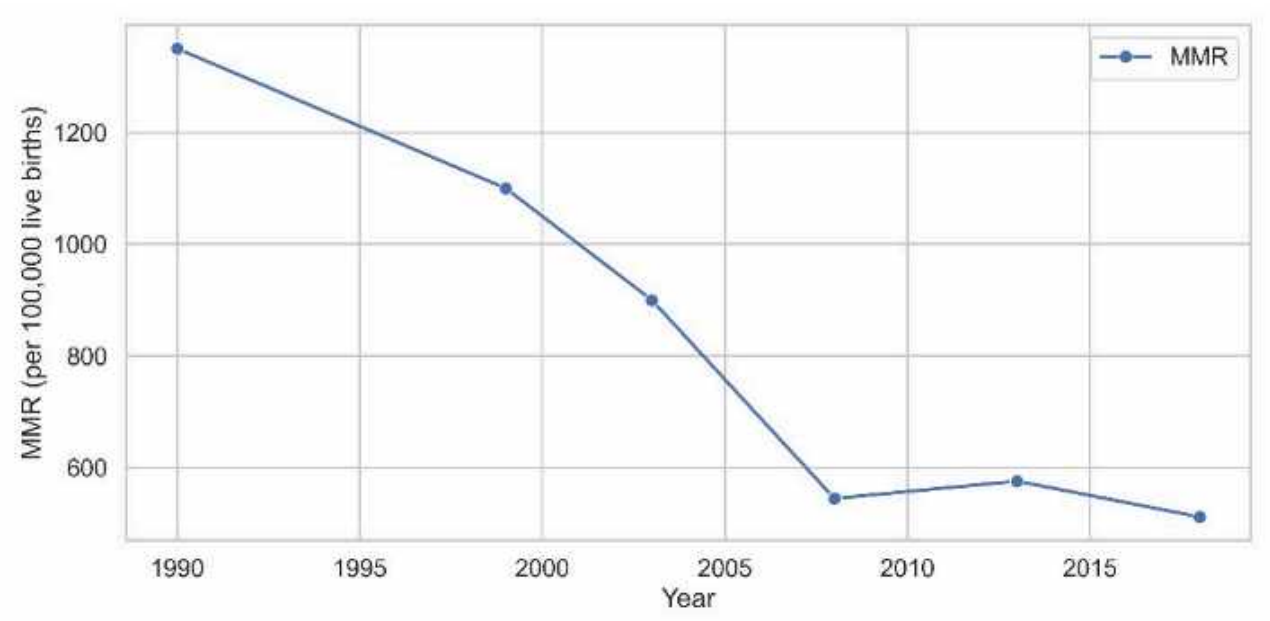


Figure 8: Trend in Maternal Mortality (NDHS 1990-2024)



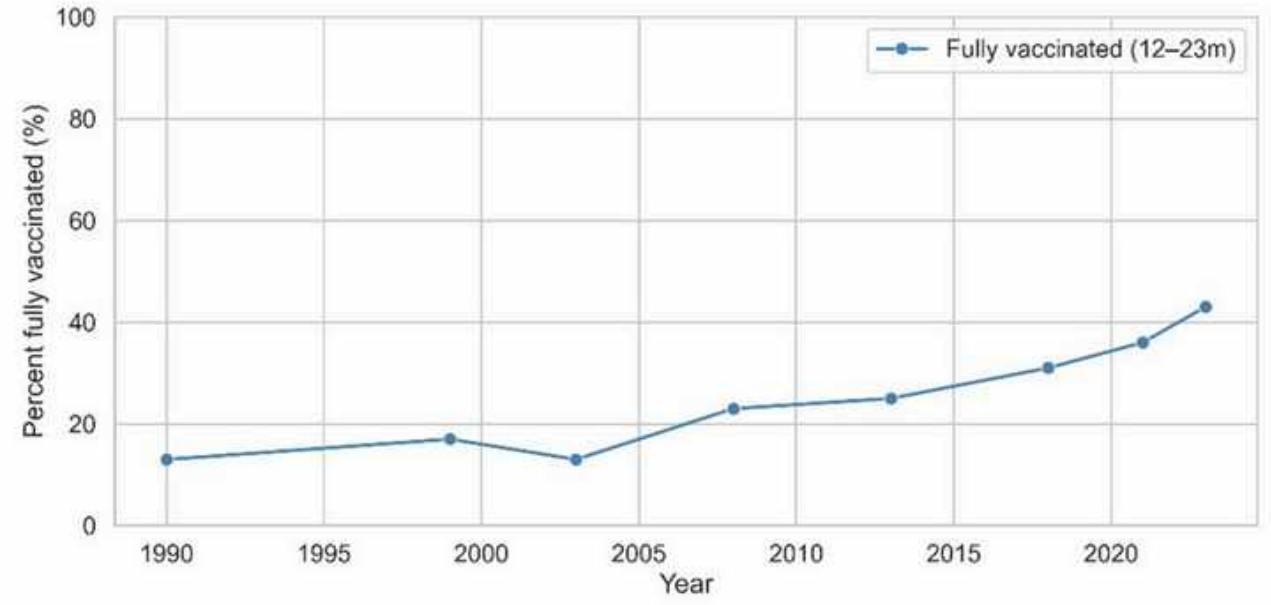


Figure 9:

Trend in children who are fully vaccinated with basic antigen, age 12-23months (NDHS 1990-2024)

Overview of the Nigeria Health System

Nigeria's health system operates within a federal structure, where responsibilities are shared across three tiers of government: federal, state, and local government authorities. The Federal Government, through the Federal Ministry of Health and Social Welfare provides overall leadership and policy direction, supported by decentralized structures at the State and Local Government Area, as well as the Federal Capital Territory and its Area Councils. The Nigerian health system is broadly structured into primary, secondary, and tertiary levels. Primary healthcare forms the bedrock of the system, providing essential services such as maternal and child health, immunizations, health education, and basic treatment. It is also central to preventive medicine, serving as the main access point for disease prevention and health promotion services. Secondary healthcare is delivered through hospitals and health centers managed by states, offering more specialized services. Tertiary healthcare includes specialized national referral hospitals and teaching institutions that provide advanced medical care, research, and training. Despite its comprehensive setup, the system faces significant challenges, including inadequate funding, shortages of healthcare workers, infrastructural deficits, and disparities in access particularly between urban and rural areas. Nigeria continues to work on reforms like the National Health Policy, the National Health Act as well as the Nigeria Health Sector Renewal Investment Initiative(NHSRII) to strengthen health governance, improve resource allocation, and move toward universal health coverage.

Nigeria Health Sector Renewal Investment Initiative (NHSRII)

The NHSRII was launched in December 2023 following its adoption by the National Council on Health - the highest decision-making body as prescribed by the National Health Act 2014. The initiative is a bold, transformative plan by the Nigerian government under the leadership of the Coordinating Minister of Health - Prof. Muhammad Ali Pate, CON. It is aimed at renewing the health system by improving governance of the health system, quality of health service delivery and overall population health outcomes. The NHSRII as shown in the figure below, contains all the right ingredients to turn Nigeria's poor health indices around. It comprises of two key programs: the Basic Health Care Provision Program (BHCPP) and the Nigeria Healthcare Industrialization Program. The BHCPP will be managed through a Sector-Wide Approach (SWAp) to improve investment and allocation of funds to the health sector via real or notional pooling of all available funds. The Nigeria Healthcare Industrialization targeting largely strengthening of Tertiary and Quatenery Care, and Medical Indistrialization will have a dedicated pool of funds to drive investment in the healthcare value chain aimed at ramping up local production of health products.

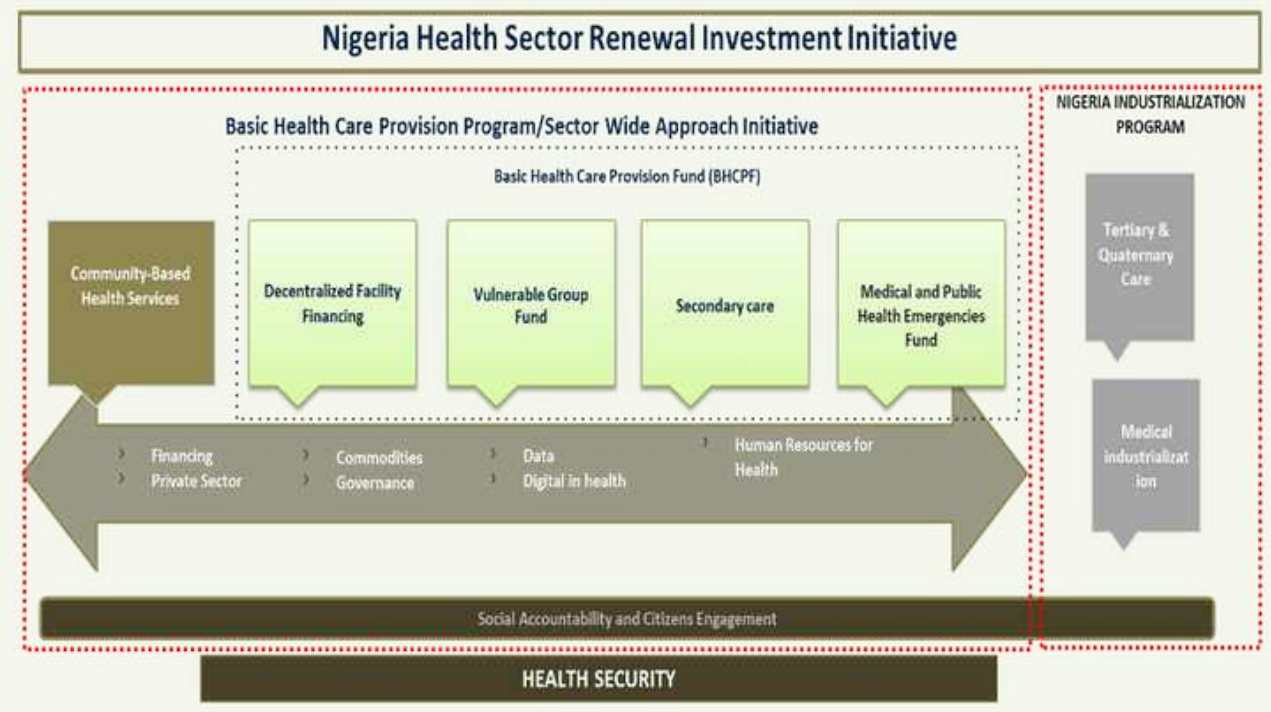


Figure 10: Components of the Nigeria Health Sector Renewal Investment Initiative (NHSRII)

The implementation of the NHSRII is guided by the Health Sector Strategic Blueprint (HSSB) whose goal is to save lives, reduce both physical and financial pains and produce health for all Nigerians. The blueprint is guided by 4 pillars and, 3 enablers (Figure 11) and consist of, 27 priority initiatives and 265 strategic interventions, all of which are tracked through a well-defined Monitoring, Evaluation, Accountability, Research and Learning (MEARL) plan. The HSSB MEARL plan guides cross-sectoral performance reviews including the Joint Annual Review (JAR) and Qquaterly Performance dialogues across all levels of the health system in Nigeria.

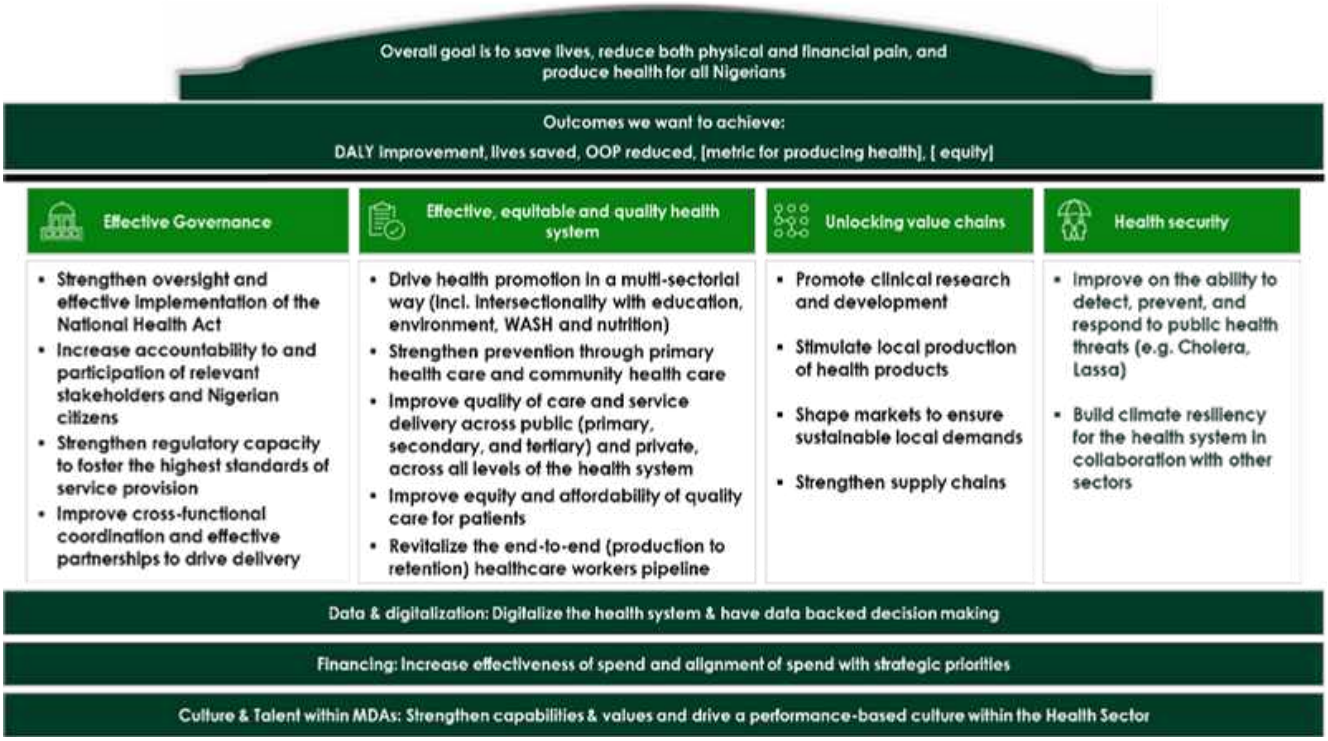


Figure 11: The Health Sector Strategic Blueprint

Purpose of 2025 Joint Annual Review (JAR)

The SWAp guiding the implementation of the NHSRII entails the adoption of 5 principles of One Plan, One Budget, One Report, One Conversation and One Voice. The One Rreport principle ensures standardization of indicators for the teh health sector in line with the HSSB MEARL plan, and to set platforms for joint reviews with all stakeholders. These platforms include the Joint Annual Reviews and Quarterly Performance Dialogue sessions.

The 2025 JAR seeks to build on the foundation laid in 2024 by deepening the review of the health sector's performance in the course of implementation of the NHSRII and broader UHC goals using the Sector Wide Approach. Specifically, the core objectives for the JAR include:

1. Review progress on the NHSRII priorities and commitments, and broader health sector performance
2. Spotlight best practices and facilitate multi-sectoral cross-learning and collaboration across core initiatives
3. Jointly identify performance optimization opportunities and align on the way forward to accelerate progress in 2026

Note: The review period for the current year covers performance during the first three quarters of 2025 (January–September 2025). Most of the service delivery data were sourced from DHIS2 platform.

Progress on UHC and SDG3 Health Targets

On many SDG-3 indicators, Nigeria is now making some incremental progress on health outcomes especially in improving immunization coverage and reducing child and maternal mortality, however the overall performance on SDG 3 remains off-track, with service coverage and financial protection still very low.

Table 1: Nigeria's SDG 3 Health target and achievements

SDG Indicator	2030 target	Latest Nigeria value (year)
Maternal mortality ratio (SDG 3.1.1)	< 70 per 100,000 live births	≈ 512 per 100,000 (NDHS 2018)
Under-5 mortality rate (SDG 3.2.1)	≤ 25 per 1,000 live births	~110 per 1,000 (NDHS 2024)
Neonatal mortality rate (SDG 3.2.2)	≤ 12 per 1,000 live births	~41 per 1,000 000 (NDHS 2024)
UHC Service Coverage Index (SDG 3.8.1)	Move toward 100 (universal coverage)	44.0 (NDHS 2024)
Population covered by health insurance / financial protection (UHC)	Universal/very high coverage by 2030	~21.1 million people enrolled (NDHS 2024)
Out-of-pocket (OOP) share of current health expenditure	Reduce substantially (SDG ambition: protect households)	> 70% (HSRM)
DTP3 / Routine immunization coverage (childhood vaccines)	≥90% global ambition	~74% (WHO 2024)

Leadership and Governance

02

This section reviews the progress made under Pillar I of the Health Sector Strategic Blueprint which emphasizes effective governance and stewardship by strengthening implementation of the National Health Act, enhancing accountability and participation, and building regulatory capacity for quality service delivery. A key element is the Federal–State coordination through the Sector-Wide Approach (SWAp) to ensure harmonized planning, financing, and accountability across the entire health system.

Implementation of Compacts and Ministerial Deliverables

Strengthen oversight

Indicator	Value
% of NCH[1] held	0 (not due)
% of 2024 NCH resolutions implemented	60%
% of SCH (2025) held	10%
% of 2024 SCH resolutions completed	0%
% of quarterly Ministerial Oversight Committee (MOC) meetings held	75%
% of quarterly performance meetings held	75%

[1] The National Council on Health (NCH) is the highest policy and decision making body for the health sector. It is replicated at the State level as the State Council on health (SCH).

Increased accountability

Indicator	Value
Donors (direct) funding commitments to the BHCPF	0%
% of states/FCT health sector planning cells that are functional	50%
% of States that have conducted the JAR	90%
% of State-level JAR conducted according to schedule (timeliness of JAR)	27%
Percentage of recommendations from federal quarterly performance dialogues implemented	85%
% of quarterly dialogues (roadshows, webinars etc.) conducted to engage/re-orient States on SWAp	75%
Number of key citizen's engagement held (electronic/print/traditional media)	150
Number of key feedback received from stakeholders and citizens Engagement Sessions	75
% of feedback from citizens/stakeholders adopted and implemented	60%
% of health-related grievances addressed by SERVICOM/other mechanisms	90%

Patients perception survey (Nigerian's Voice Survey)

The 2025 Patient Perception Survey, conducted across 36 states and the FCT with a nationally representative sample of 2,657 respondents, provides useful insights into citizens' interaction and perception of the Nigerian healthcare system. The majority (64%) of respondents reported visiting a health facility 1–5 times in the past year, though preventive care services such as sexual health remain underutilized (26%). Health insurance coverage remains low at just 12%.

Patient Utilization of the Healthcare System

64%
respondents reported visiting a health facility between 1-5 times in the past 12 months

26%
of respondents received sexual health services (low uptake of preventive care services across most areas)

12%
of respondents are on health insurance

Patient Satisfaction and User Experience

75%
Overall quality of care ratings (Reported high level of satisfaction for respondents who have used the healthcare system within the past 4 weeks)

75%
of respondents satisfied with their overall healthcare experience

22%
of respondents perceived unnecessary delay in accessing care, with consultations and inb taking the longest time

Patient Endorsement and Confidence in the Health System

48%
of respondents feel health secured that they can get and afford quality care if sick

47%
of respondents are confident that the Government considers public opinion in health system decisions

67%
of respondents are confident in Government's capacity to effectively manage health emergencies

55%
of respondents endorsed the trajectory of the health system

77%
of respondents endorsed the current health system

Figure 12: Patients perception survey (Nigerian's Voice Survey)

Demography of Respondent in the 2025 Nigerians' Voice Survey

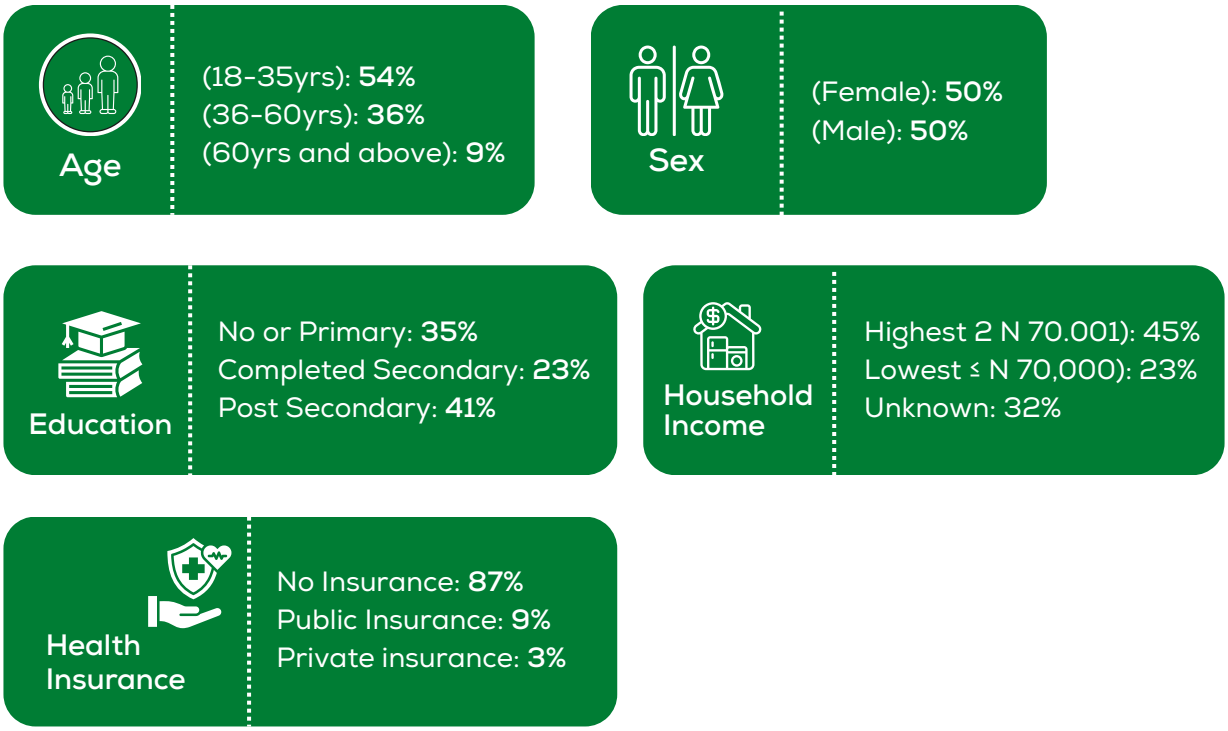
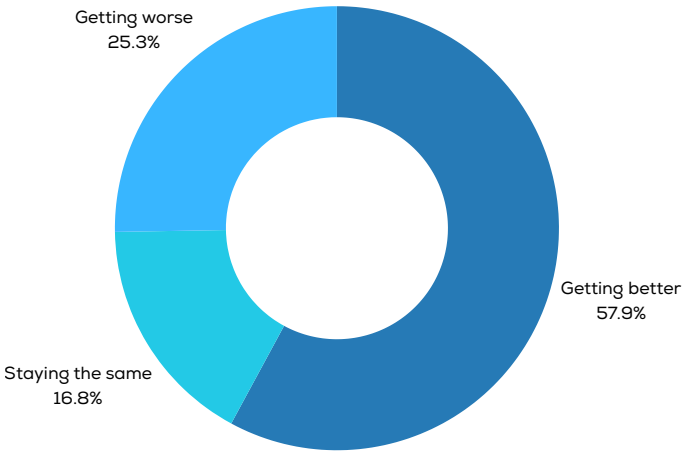


Figure 13: Demography of Respondents the 2025 Citizens Voice Survey

The 2025 Patient Perception Survey, conducted across 36 states and the FCT with a nationally representative sample of 2,657 respondents, provides useful insights into citizens' interaction and perception of the Nigerian healthcare system. The majority (64%) of respondents reported visiting a health facility 1–5 times in the past year, though preventive care services such as sexual health remain underutilized (26%). Health insurance coverage remains low at just 12%. Satisfaction with the healthcare system is relatively high, with 75% of respondents rating the overall quality of care positively. While most respondents (73%) spent less than an hour during health visits, 22% perceived delays and inefficiencies during service delivery.

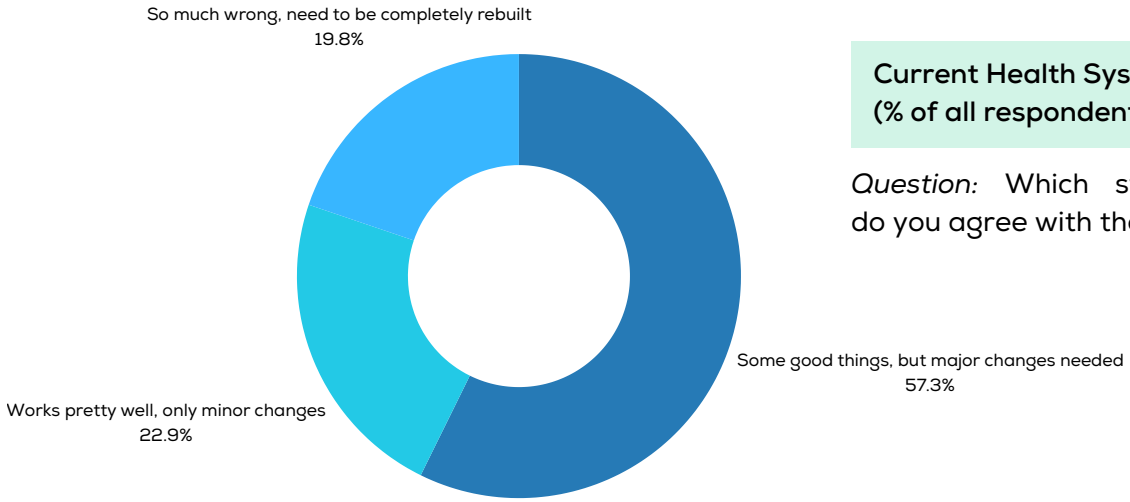
Patients' confidence in the health system shows there is need for improvement: only 48% feel assured they can access and afford quality care when sick, and 47% believe the government values public input in health decisions. Many respondents (67%) expressed confidence in the government's ability to manage health emergencies effectively. Source: NOIPolls Patient Perception Survey Data (2025)

Overview of Respondents' endorsement of the healthcare system



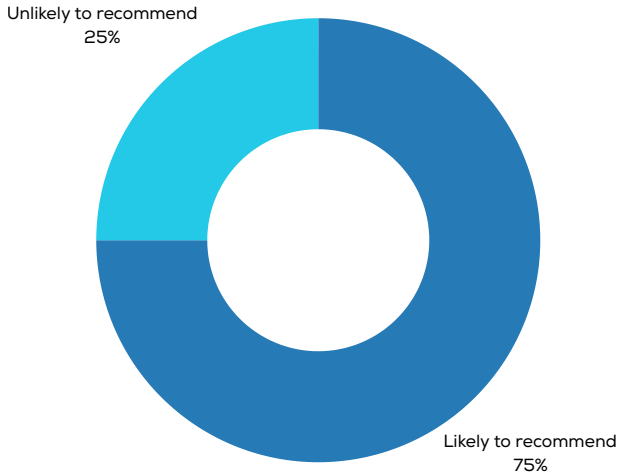
Health system trajectory over past 2 years (% of all respondents)

Question: Thinking about the past two years, would you say Nigeria's health system is getting better, staying the same or getting worse?



Current Health System (% of all respondents)

Question: Which statement do you agree with the most?



% of all respondents likely to recommend healthcare facility

Question: How likely is it that you would recommend this healthcare provider or facility to a friend or family member?

Figure 14: Respondents Endorsement of the Health System

Strengthen regulatory capacity

Certification of Health Facilities

Indicator	Value
% of PHC facilities issued certificates of standards	0%
% of PHCs (public/private) that are BEmONC certified (BHCPF focused)	0%
% of SHC facilities (public) issued certificates of standards	0%
% of SHC facilities (private) issued certificates of standards	0%
% of FTH facilities (public) issued certificates of standards (provisional)	23%
% of Tertiary facilities (State owned) issued certificates of standards	0%
% of Tertiary facilities (private) issued certificates of standards	0%

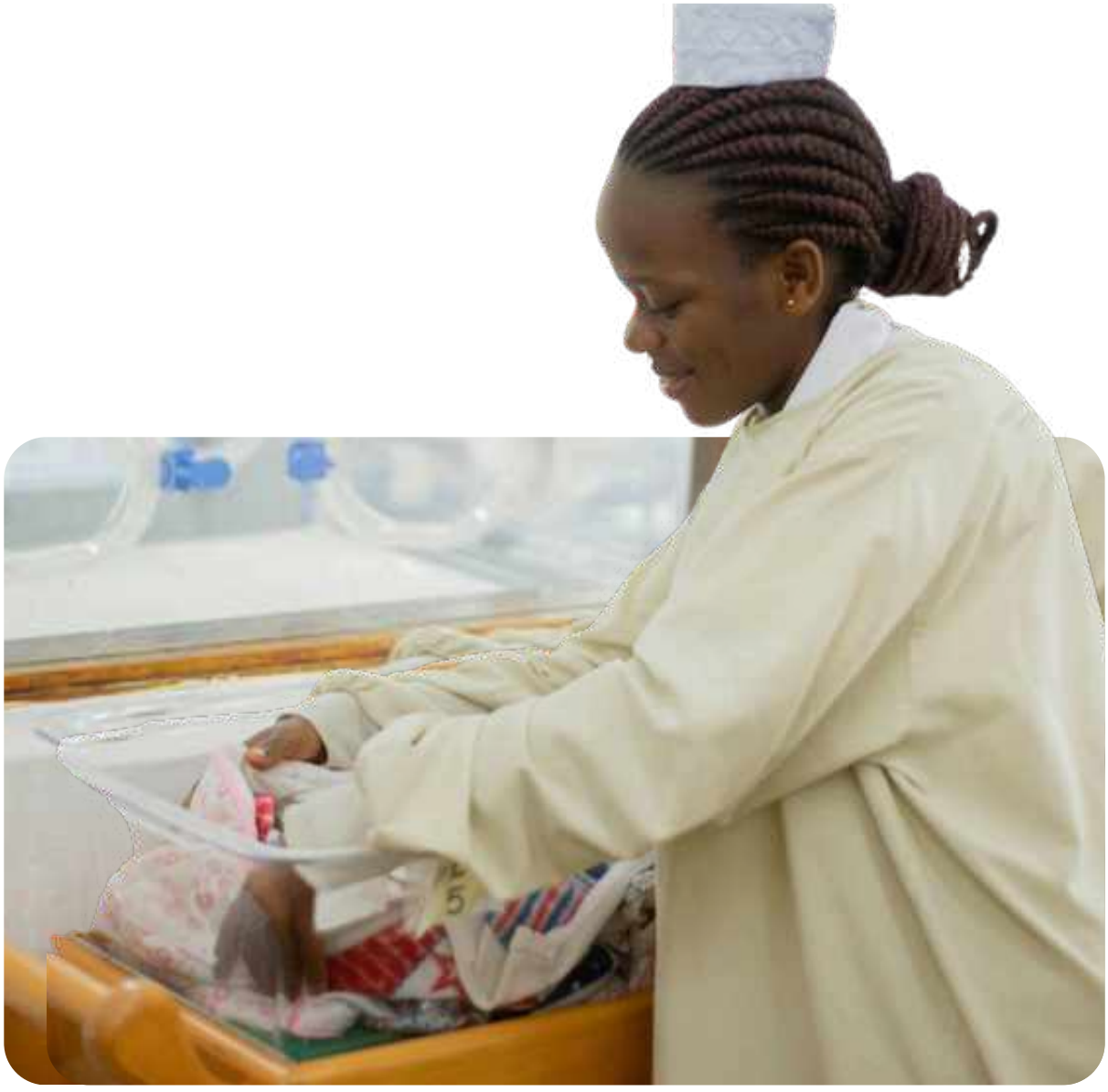
At the end of Quarter 3, 2025, Nigeria assessed and certified 1,774 PHCs to be BEmONC ready. SHC facilities were also assessed but none was certified to be CEmONC ready in line with national minimum standards, covering infrastructure, staffing, essential medicines, and service delivery. The Standards Tertiary committee issued provisional certificates of standards to 20 of 84 Federal Tertiary Facilities

Human Resources Regulation

Indicator	Value
% of regulatory bodies that have fully digitized registers of health workers they regulate	20%
% of public schools/colleges of health issued waivers/accredited to train increased numbers of health workers (doctors, nurses/midwives etc.)	0%
Percentage of practicing health professionals who are fully licensed	95%
Percentage of Pharmacists in Service who were licensed	94%
Percentage of Colleges of health technology accredited across Pharmacy Schools/Colleges of Health Technology	71% (17 of 24 planned accreditations)

Food and Drug Regulation

Indicator	Value
Percentage of Drug Products Analyzed within defined timeline	112% (6727/6000)
Number of Food Products Analyzed within a defined timeline	17,266
Number of outlets visited with Pharmacovigilance and Post-market surveillance of health products (medicines, vaccines and other health-related products)	12,629
Proportion of Marketing Authorization decisions taken within 240 Days for New registration of Drug products	34.5 (829/2400)



Improve cross-functional coordination & effective partnerships

Performance of Annual Operational Plans

Indicator	Value
Planning	
Proportion of set targets in the health sector workplans met	20
% of States AOP that aligns with the priorities of the HSSB and NSHRII	100%
% of States/FCT that completed their 2025 AOP	100%
% of States/FCT with Development Partners' funding commitment in the costed AOP	90%
% of AOP Total Cost Allocated to PHC System	24.3%
% of AOP Total Cost Allocated to SHC & THC	20.2%
% of AOP Total Cost Allocated to Governance, Administration & Support Services	55.5%
AOPs with LGA/health facility plans consolidated	62%
Government Commitment as share of Total AOP Cost	46.4%
Partners' Commitment as share of Total AOP Cost	34.0%
Funding Gap	19.6%

Implementation

% of quarterly AOP reviews conducted using the revised national AOP review tool	24.3%
% Implementation of AOP Activities (Aggregate)	44.7%
% Implementation of AOP Activities – Government Commitment	38.4%
% Implementation of AOP Activities – Partners' Commitment	50.5%
% Implementation of AOP Activities – Joint Commitment	43.7%
Proportion of recommendations from AOP quarterly review meetings implemented	0%

Key Achievements

There have been significant gains made in strengthening governance and leadership in the health sector with governance structures such as NCH, MOC, SOCs, and other planned quarterly or yearly meetings being held on average of more than 50%.

Accountability mechanisms and citizens engagement are also improving as exemplified by conduct of State JAR in over 90% of States, and citizens participation in sector decision-making at all levels through various channels.

In 2025, more partnerships continued to be strengthened at all levels. The sector at all levels recorded closer collaboration with order MDAs and, improved collaborations with donors, development partners, and the private sector.

Gaps and Bottlenecks

A key gap that persists in governance of the health sector is appropriate regulation. Although standards have been established for PHCs and FTHs, this is yet to be developed for secondary levels of care. Institutionalization of the set standards across all levels of care is still low and sub-optimal. Similarly, the regulation of health professionals through appropriate licensing and monitoring of professionals in practice remained low in 2025.

There is poor mention as well as evidence of private sector participation in the NHSRII as part of effective collaboration.

AOP is currently limited in informing health budgets due principally to delays in commencement of the development process and in resolving bottlenecks in the roadmap.

Recommendations

1. States are encouraged to issue certificates of standards in line with the provisions of the National Health Act 2014 to qualifying facilities that have been assessed to be BeMONC and CeMONC ready. Similarly, the Standards Tertiary Committee should be resourced (financial and technical) to assess, issue to and monitor Certificates of Standards in Tertiary hospitals (FTHs, State owned THs and Private owned THs) across the country.

2. Regulatory bodies should be empowered to fully digitize their health workforce registry and maintain a functional database of licensed human resource to enable periodic tracking of availability and distribution of all cadre of healthcare workers in the Country,

3. Private sector collaboration should be established as the fourth enabler in the implementation of the NHSRII.

4. There is a need for NAFDAC to collaborate with other relevant agencies, such as the National Orientation Agency (NOA), the Federal Competition and Consumer Protection Commission (FCCPC), the Ministry of Environment, and other line ministries, to enhance public awareness and sensitization on how to report cases of fake drugs and products.

5. To avoid delays in future AOP processes, the FMoH&SW should ensure early planning and capacity-building. With tools now available, the AOP process should commence ahead of the State budget calendar to ensure full alignment between AOP priorities and budget proposals. Regular technical assistance and a synchronized national AOP and budgeting timeline will help integrate planning and financing more effectively.

Pillar II: Health Service Delivery

03

This section reviews the progress made under Pillar II of the Health Sector Strategic Blueprint which seeks to deliver an efficient, equitable, and quality health system by scaling health promotion through multi-sectoral action, strengthening prevention at primary and community levels, and raising the standard of care across public and private providers. It emphasizes expanding insurance coverage to improve affordability and equity, while revitalizing the healthcare workforce pipeline to ensure sustainable service delivery.

Service Availability & Readiness

Indicator	Value / Status
Number of Secondary Facilities that meet Quality of Care criteria for CEmONCs	308
Number of refurbished and empaneled CEmONC facilities	232
Number of women receiving CEmONC services	16,719,609
Number of neonates receiving CEmONC services	1,456,923
Number of women that had vesico-vaginal fistula surgeries	1,707
Proportion of women that had vesico-vaginal fistula surgeries	77%
Availability of climate-resilient health infrastructure models and blueprints	99

Health Infrastructure and Service availability

Number of Health Facilities (Source: DHIS2)

Indicator	Value / Status
Primary Health Centres	30,903
Secondary Health Facilities	9,765
Tertiary Health Facilities	182
Quaternary Hospitals	0
Total Number of Facilities	40,856
Laboratories & Diagnostic Services	4,000 (registered with MLSCN)
Registered Functional Blood Banks Nationwide (public/private)	30 (NBTS)

Facility Type	Public	Private
Primary Health Centres	27, 442	3,460
Secondary Health Facilities	1,144	3,779
Tertiary Health Facilities	115	58
Quaternary Hospitals	0	–

Total number of PHCs revitalized in 2025	1,610
Total number of priority equipment procured and deployed to PHCs	68,500
Number of Participating States receiving funds in compliance with allocation formula in revised guidelines	37
Proportion of States delivering the Harmonized Package of BHCPF (NHIA & NPHCDA Gateway) Services at the Last Mile	37
Percent of States using the digitized process steps for accessing BHCPF funds	100%
Percentage increase in quarterly operational budget to enhance fiduciary oversight, intensify monitoring, and LGA supervision	100%

Functional Bedspace

Number of functional beds (PHC)	(Not Available)
Number of functional beds (SHC)	(Not Available)
Number of functional beds (Tertiary)	33,641 (FTHs)

Healthcare Facility Distribution Across Nigeria States

The distribution of health facilities across Nigeria is illustrated in three maps (Figure 15-17) below showing the spatial spread of Primary Health Care (PHC) facilities, Secondary Health Facilities (SHF), and Tertiary Health Facilities (THF). The maps highlight variations in facility density across states, as represented with different color codes.

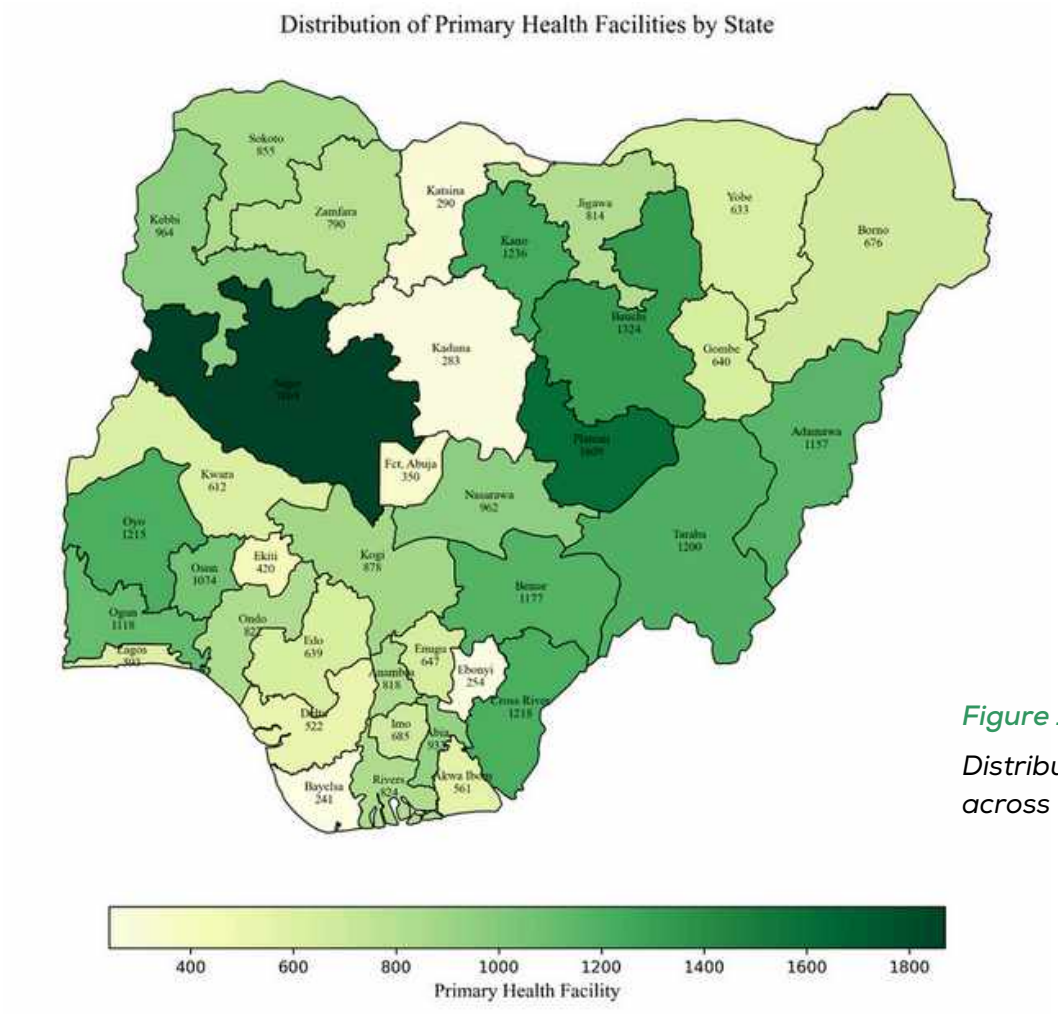


Figure 15

Distribution of PHCs across the Country

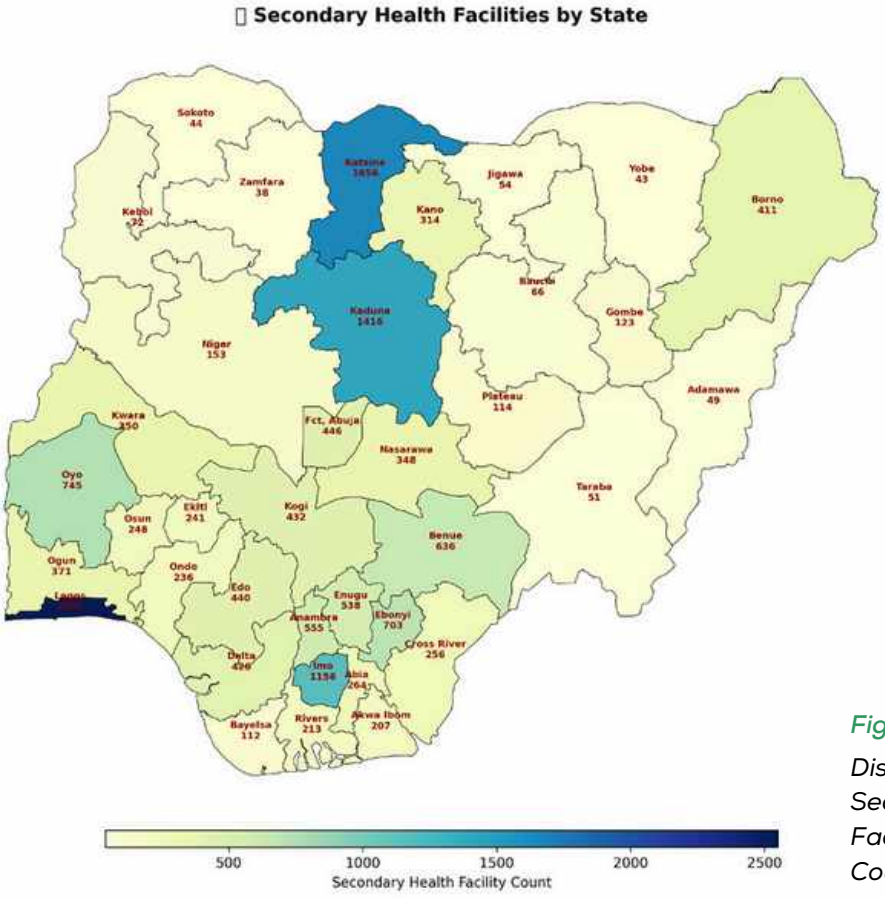


Figure 16

Distribution of Secondary Health Facilities across the Country

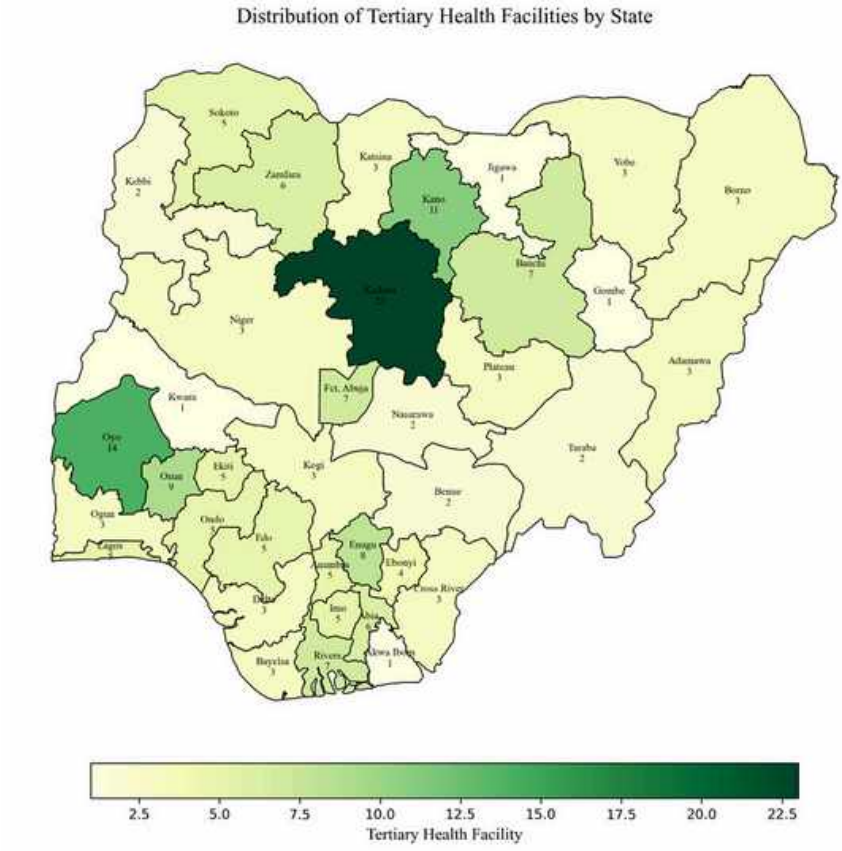


Figure 17

Distribution of Tertiary Health Facilities across the Country

Improve Quality of Care and Service Delivery Across all levels of Care

RMNCAH+N Outcomes and Service Coverage

This section presents key performance indicators on RMNCAH+N to assess progress in improving the quality of care and service delivery across health facilities in all states. The subsequent charts and analysis highlight trends in RMNCAH+N outcomes and service coverage.

Reproductive & Maternal Health

Indicator	Value
New FP Acceptor	123,300
Facility Maternal Mortality	3,689
Facility Maternal Deaths Reported in BHCPF Facilities	698
Number of women diagnosed of VVF	2,226
% of women diagnosed and treated for VVF	77%
Percentage of Facility-Based Deliveries Attended by Skilled Birth Attendants	93%
Percentage of Deliveries Attended by Skilled Birth Attendants (BHCPF focused)	87.7%
Antenatal Care (ANC) ≤ 20 weeks	2,137,819
Antenatal Care (ANC) ≥ 20 weeks	3,062,233
1st ANC before 20 weeks in BHCPF facilities	1,050,105
4th ANC visits in BHCPF facilities	1,218.855

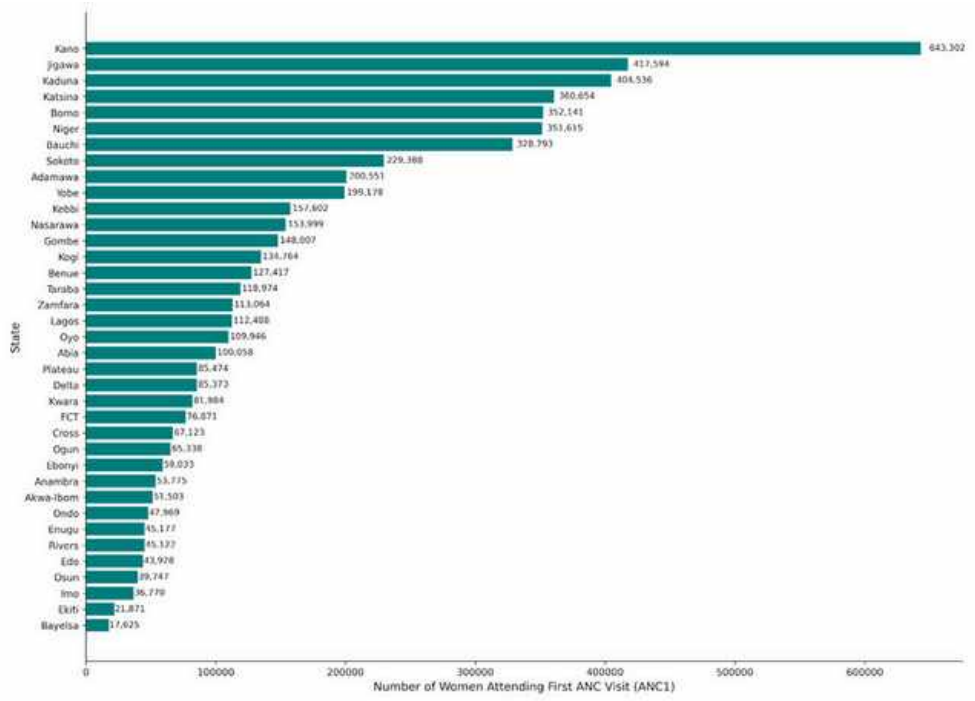


Figure 18

State Level Distribution of ANC1 Coverage in Nigeria *(Source: FASTR Adjusted DHIS2 Data 2025)*

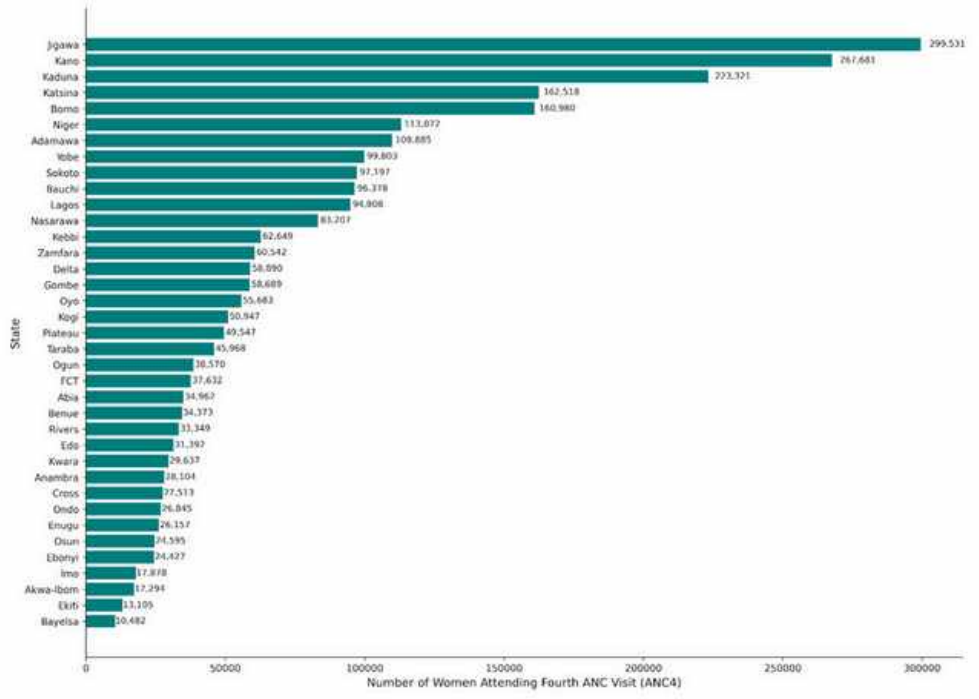


Figure 19

State Level Distribution of ANC1 Coverage in Nigeria *(Source: FASTR Adjusted DHIS2 Data 2025)*

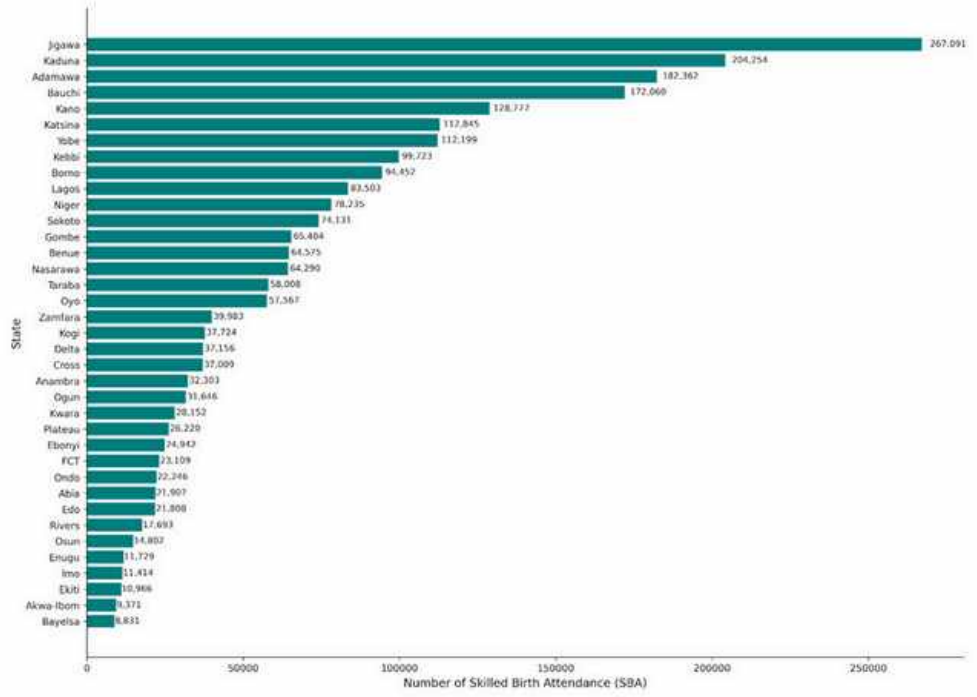


Figure 20

State-Level Distribution of Skilled Birth Attendance in Nigeria *(Source: FASTR Adjusted DHIS2 Data 2025)*

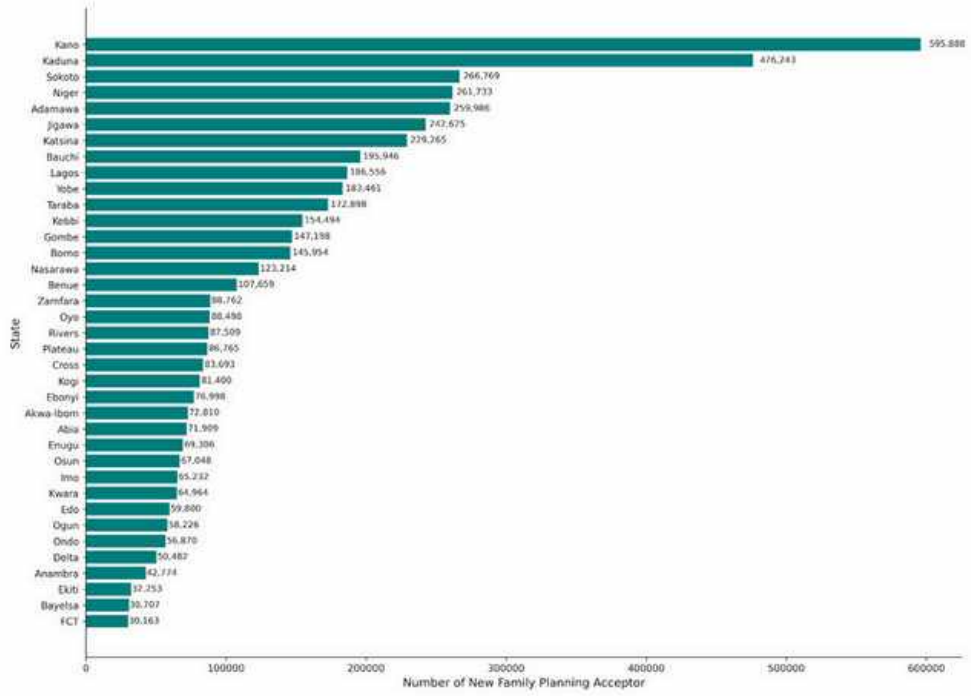


Figure 21

State-Level Distribution of New Family Planning Acceptor in Nigeria *(Source: FASTR Adjusted DHIS2 Data 2025)*

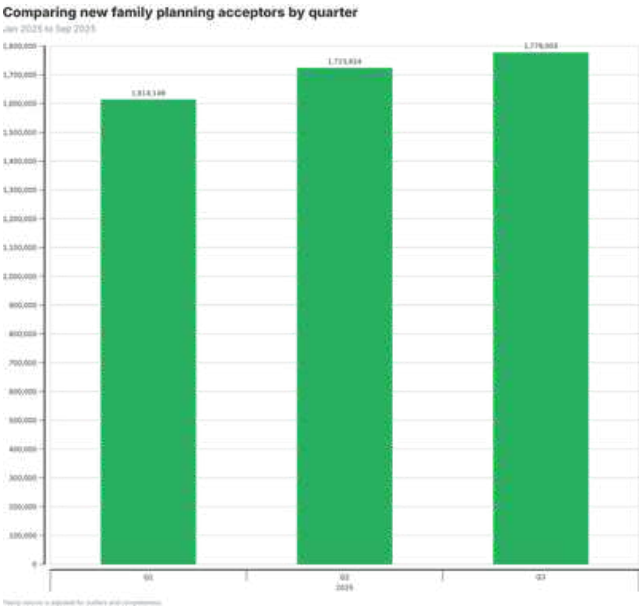


Figure 22

Comparing New FP Acceptors by Quarter

Family Planning

New family acceptors have increased steadily each quarter, with an overall 10.2% increase from Q1 2025 to Q3 2025. This is a promising trend for crashing maternal mortality.

Compared to 2024, starting from March 2025, there's a notable positive divergence between actual and expected new family planning acceptors. This increase continues throughout 2025, with the peak in May 2025 alone reaching approximately 100,000 more new family planning acceptors than expected based on historical trends (shaded in green).

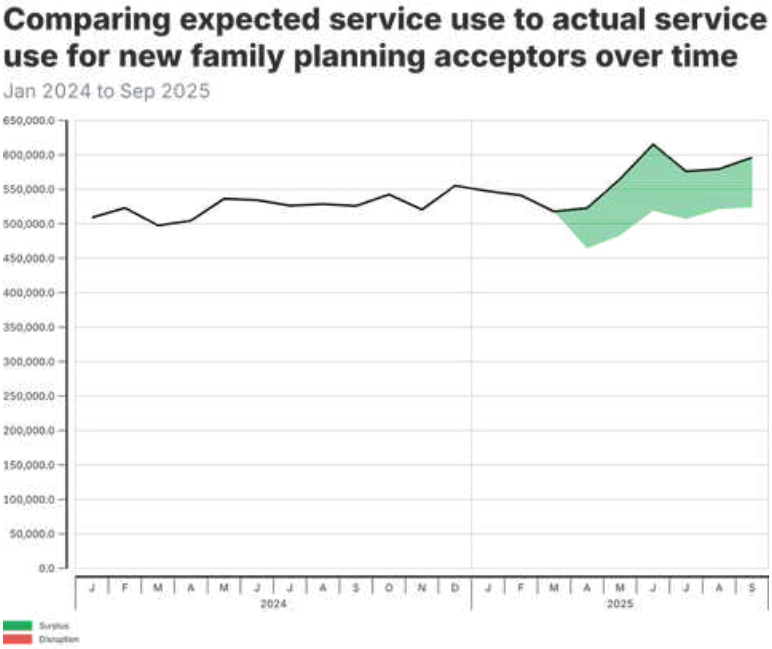
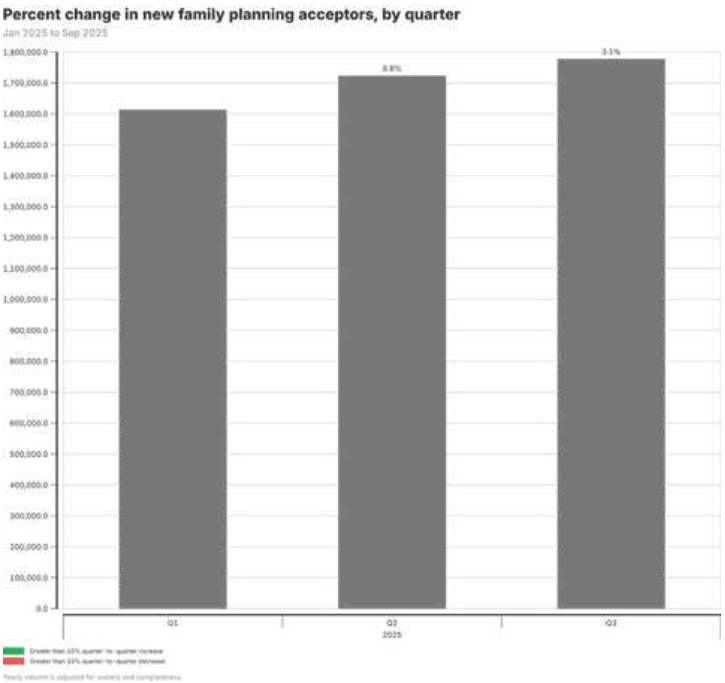


Figure 23

Comparing Expected Service Use to Actual Use

This graph quantifies changes in service volume compared to historical trends and accounting for seasonality. These signals should be triangulated to other data and contextual knowledge to determine if the results are an artifact of data quality. Unexpected volume changes are estimated by comparing the observed volume to the expected volume based on historical trends and seasonality. Previous large unexpected changes in the historical data are removed. This analysis is an interrupted time series regression with facility-level fixed effects. Data is adjusted for outliers and completeness



Comparing each quarter of 2025, Q2 recorded a 6.8% increase in new family planning acceptors compared to Q1, while Q3 maintained the upward trend with a 3.1% increase over Q2. Overall, from January to September 2025, acceptor numbers grew steadily, starting at approximately 1.6 million in Q1, rising to about 1.7 million in Q2, and reaching roughly 1.75 million in Q3.

Figure 24

Percentage Change in New FP Acceptors by Quarter

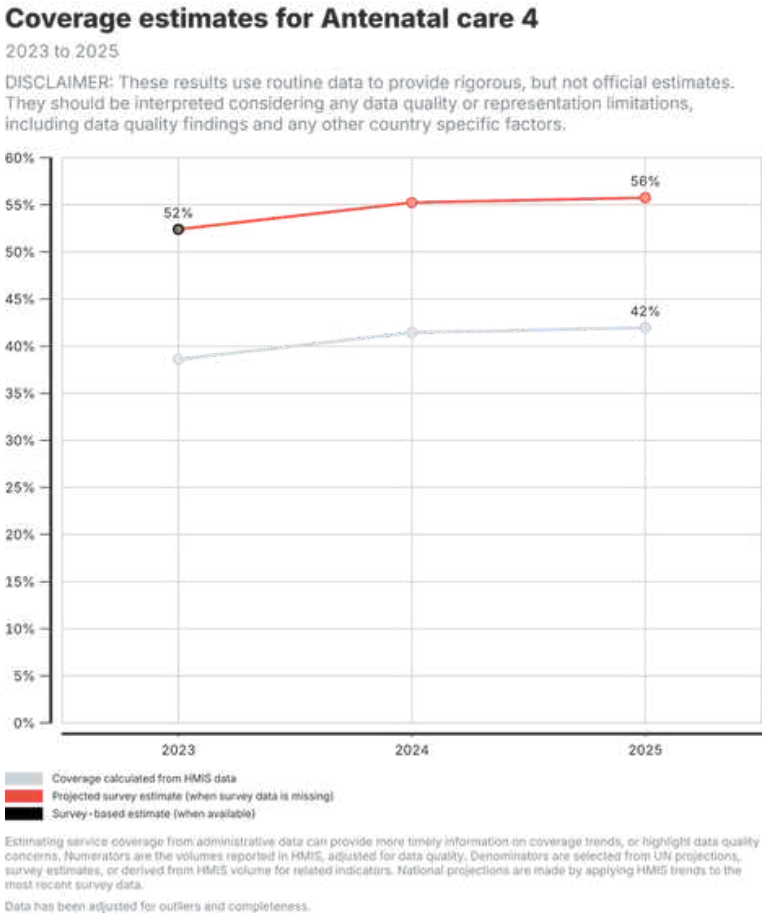
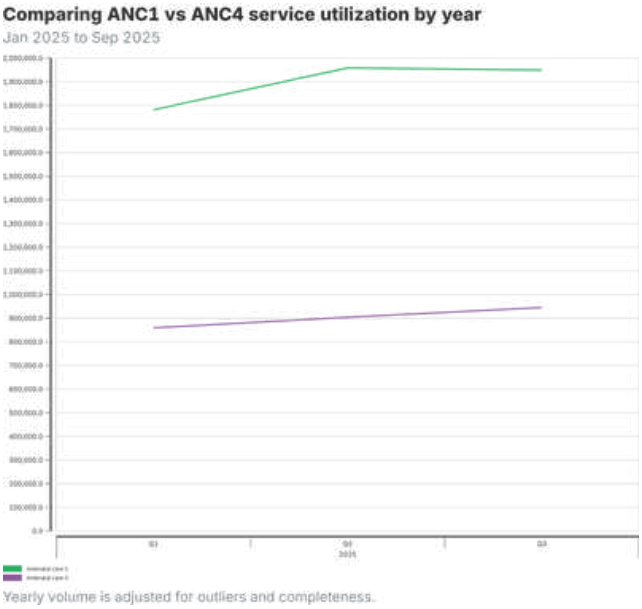


Figure 25

Coverage of Fourth Antenatal Care Visit (ANC4), Nigeria, 2023 - 2025

Coverage of the recommended fourth antenatal care visit (ANC4) has shown gradual improvement between 2023 and 2025. Routine HMIS data indicate that ANC4 coverage was 39% in 2023, while the corresponding survey-based estimate was higher at 52%. Projections for 2024 and 2025 suggest coverage levels of 56% in both years.



In 2025, ANC1 consistently showed much higher utilization than ANC4, with volumes exceeding 1.78 million in Q1, peaking at 1.96 million in Q2, and slightly declining to 1.95 million in Q3. In contrast, ANC4 utilization remains significantly lower than ANC1 but shows a steady upward trend, starting at 856,629 in Q1, rising to 904,072 in Q2, and reaching 944,859 in Q3. This pattern suggests strong initial engagement with antenatal care but a notable drop-off in follow-up visits

*Figure 26: **Trends in Antenatal Care Utilization, January - September 2025***

In 2025, ANC1 consistently showed much higher utilization than ANC4, with volumes exceeding 1.78 million in Q1, peaking at 1.96 million in Q2, and slightly declining to 1.95 million in Q3. In contrast, ANC4 utilization remains significantly lower than ANC1 but shows a steady upward trend, starting at 856,629 in Q1, rising to 904,072 in Q2, and reaching 944,859 in Q3. This pattern suggests strong initial engagement with antenatal care but a notable drop-off in follow-up visits

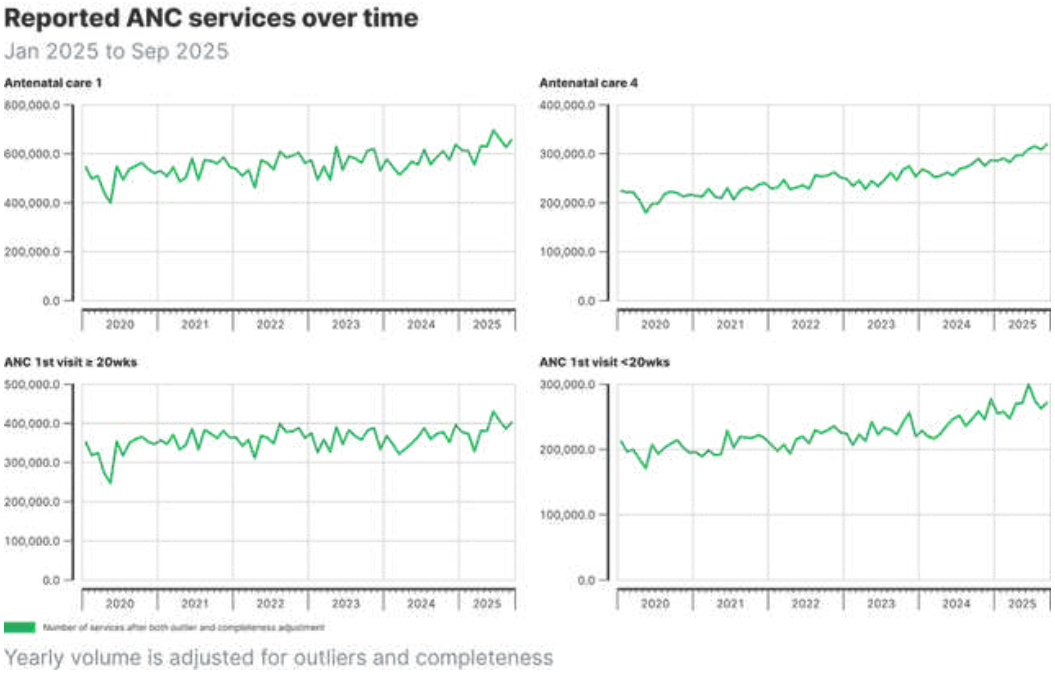


Figure 28

Trends in Antenatal Service Utilization, 2020 - 2025

All selected ANC indicators display an upward trend from 2020 to 2025, with ANC1 and ANC4 showing greater-than-expected increases in 2025 compared to historical patterns, a positive sign of progress toward reducing maternal mortality.

This improvement was observed across all zones for ANC1 and in all but the North-East for ANC4, indicating broad gains in service uptake. From January 2020 to September 2025, ANC1 visits rose steadily from about 600,000 to over 700,000, while ANC4 visits increased from roughly 200,000 to nearly 370,000, reflecting improved continuity of care. Early ANC visits (<20 weeks) also grew from around 180,000 to nearly 280,000, signaling progress in timely care, whereas late first visits (≥20 weeks) remained high and relatively stable at 350,000–400,000, underscoring persistent delays in early booking. These trends highlight significant gains in ANC coverage but emphasize the need for targeted interventions to reduce late bookings and strengthen follow-up for subsequent visits.

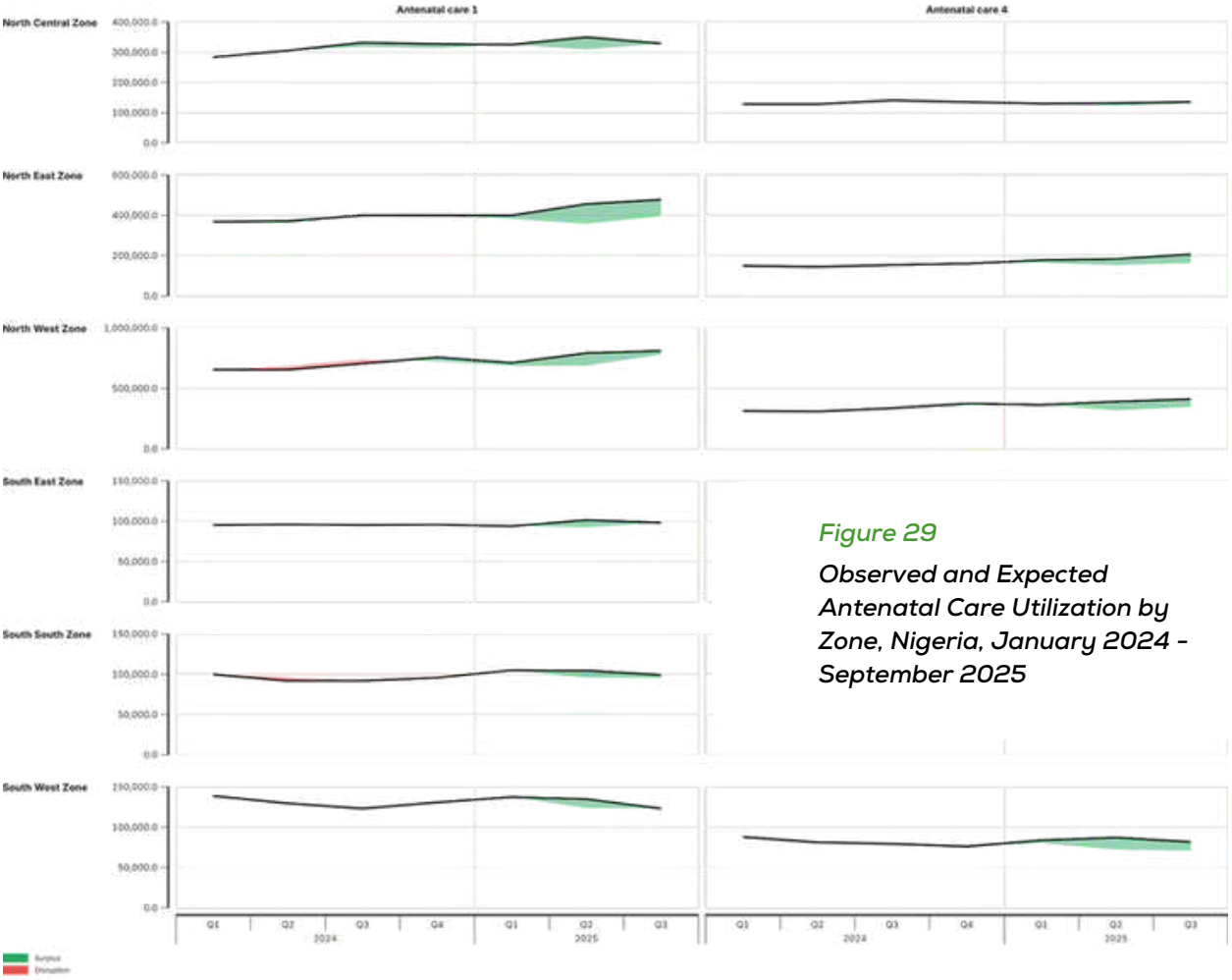


Figure 29

Observed and Expected Antenatal Care Utilization by Zone, Nigeria, January 2024 - September 2025

This graph quantifies changes in service volume compared to historical trends and accounting for seasonality. These signals should be triangulated to other data and contextual knowledge to determine if the results are an artifact of data quality. Unexpected volume changes are estimated by comparing the observed volume to the expected volume based on historical trends and seasonality. Previous large unexpected changes in the historical data are removed. This analysis is an interrupted time series regression with facility-level fixed effects. Data is adjusted for outliers and completeness

Analysis of antenatal care utilization across Nigeria's six geopolitical zones shows variation in both initiation of care (ANC1) and completion of at least four visits (ANC4) when compared with expected service volumes with the South-East and South-South slightly exceeding expectations, while ANC4 completion lagged in most zones. The North-Central and North-West experienced notable gaps between first and fourth visits, the North-East showed gradual but insufficient improvement, and the South-West made steady progress yet remained below projections.

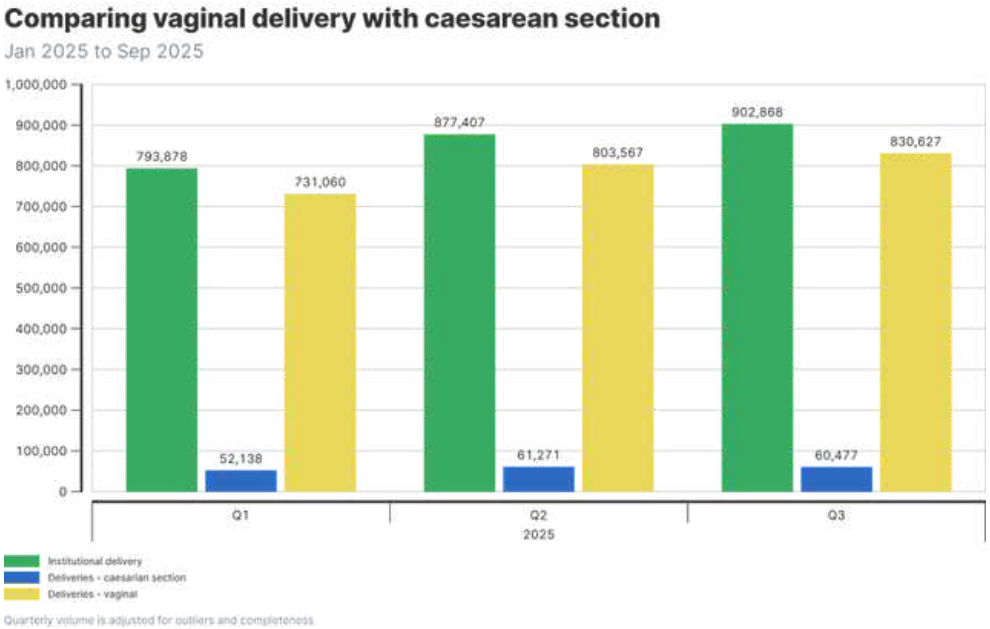


Figure 30

Number of reported deliveries that are vaginal and caesarian section

Across 2025, caesarian section is approximately 6.5 - 7% of reported deliveries each quarter. The lower cesarean section rate in 2025 may indicate limited access to higher-level delivery services. Caesarean section rates vary widely across the country, suggesting different patterns of access and treatment. South-West has the highest rate, at 26% of reported institutional deliveries in 2025 (driven by particularly high rates in Lagos and Oyo), followed by South-South (12.7%) and South-East (12.7%). In contrast, Northern Nigeria has markedly lower rates, with North-Central at 7.7%, North-West at 3%, and North-East at 2%. Sokoto, Adamawa, Yobe, and Zamfara states have the lowest rates in these zones, at 1-2%.

Deliveries attended by skilled birth attendants

Across the country, both institutional deliveries and deliveries by skilled birth attendants show a consistent upward trend across all quarters of 2025. Institutional deliveries are consistently above skilled deliveries, showing a persistent gap in skilled deliveries compared to institutional deliveries. Across 2025 and according to quality adjusted DHIS-2 data, the percentage of deliveries attended by skilled birth attendants is 92.76%.

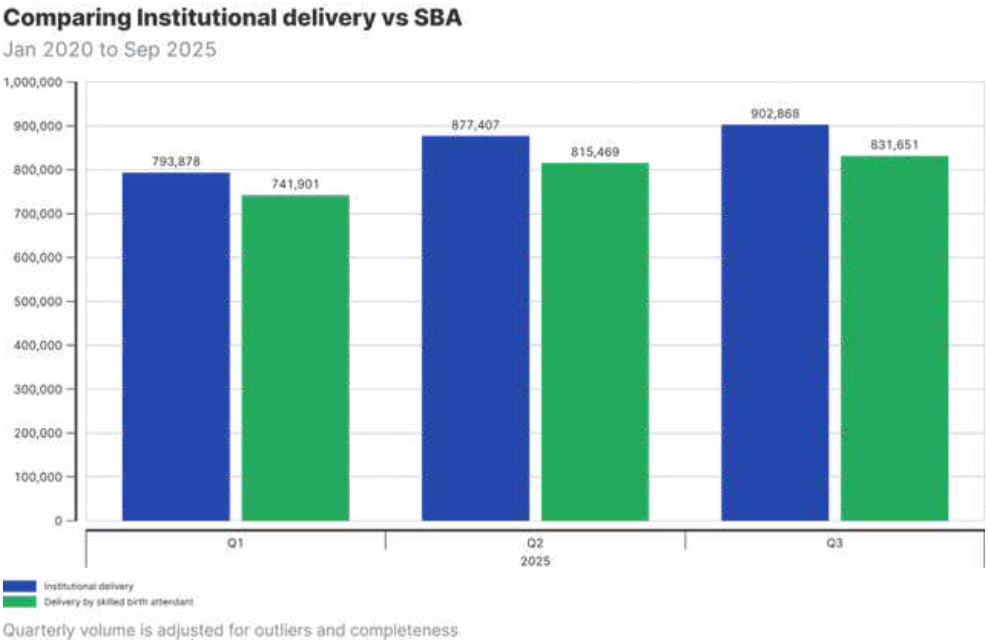


Figure 31

Institutional Deliveries and Deliveries by Skilled Birth Attendant, Nigeria, January - September 2025

Between January and September 2025, both institutional deliveries and deliveries attended by skilled birth attendants (SBAs) showed steady increases. Institutional deliveries rose from 794,617 in the first quarter to 902,868 in the third quarter. Similarly, deliveries attended by SBAs increased from 741,446 in the first quarter to 831,051 in the third quarter. Although institutional deliveries consistently outnumbered SBA-attended deliveries.

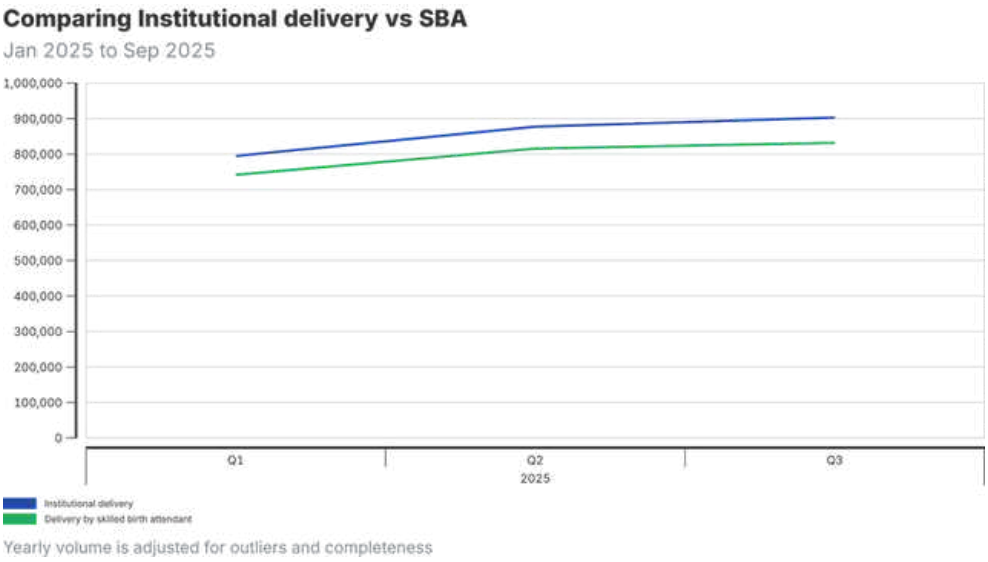


Figure 32

Trends in Institutional Deliveries and Deliveries Assisted by Skilled Birth Attendants, Nigeria, January–September 2025

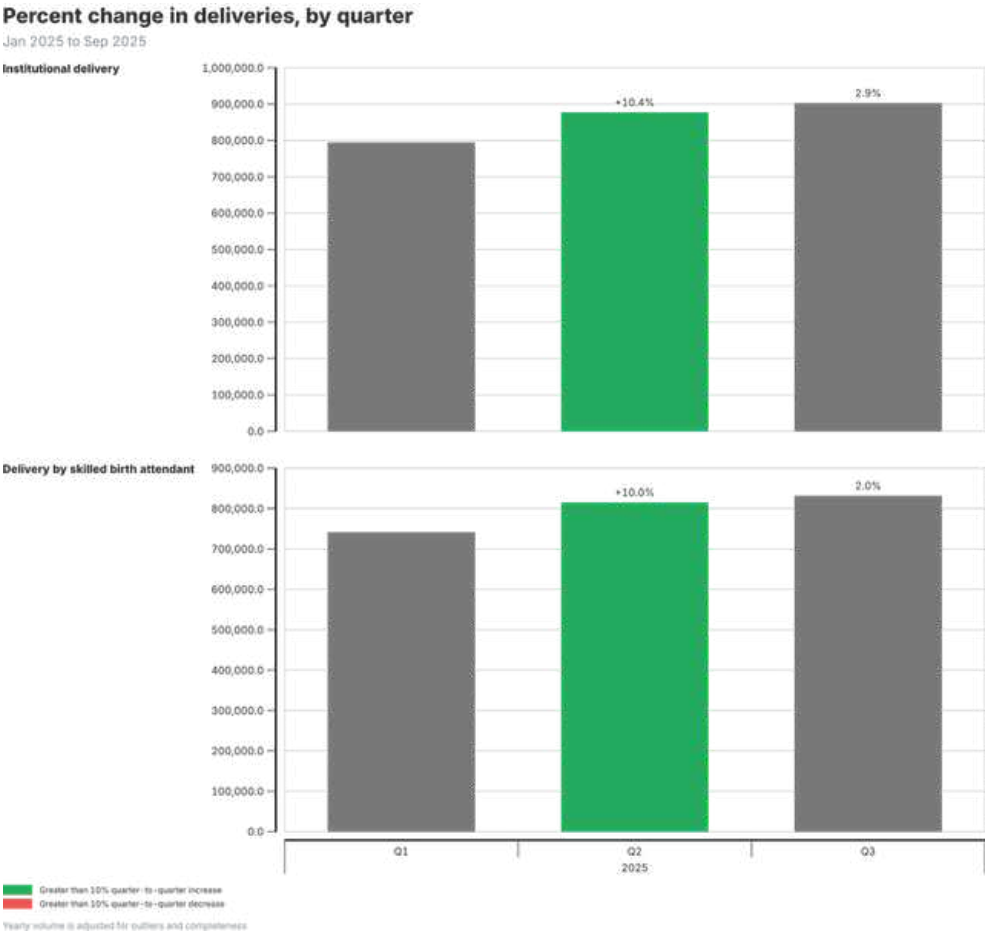


Figure 33

Quarterly Percent Change in Institutional Deliveries and Deliveries by Skilled Birth Attendants, Nigeria, January–September 2025

Between January and September 2025, both institutional deliveries and deliveries attended by skilled birth attendants (SBAs) recorded notable increases in the second quarter, followed by more modest gains in the third quarter. Institutional deliveries rose by 8.4% in Q2 and by 2.9% in Q3, while SBA-attended deliveries increased by 8% in Q2 and 2% in Q3.

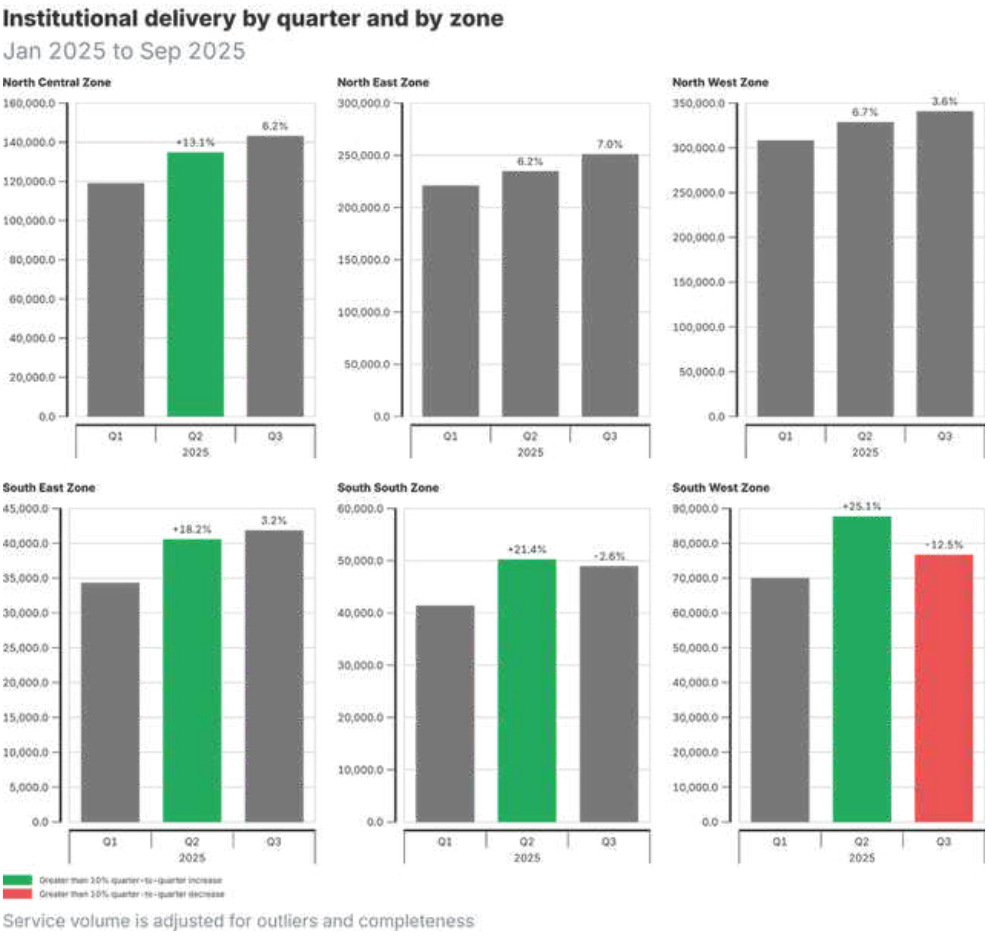


Figure 34

Institutional Deliveries by Zone and Quarter, Nigeria, January–September 2025

Institutional delivery volumes varied across zones between January and September 2025. In the North-Central Zone, deliveries increased steadily, rising by 6.1% in the second quarter and 6.2% in the third quarter. The North-East Zone also recorded consistent growth, with increases of 6.3% in Q2 and 7% in Q3. In the North-West Zone, deliveries rose modestly in Q2 (3.3%) but remained unchanged in Q3. Overall, the data suggest steady improvements in institutional delivery in most zones, with particularly strong gains in the South-South and North-East. However, there is stagnation in the North-West and the decline in the South-West.

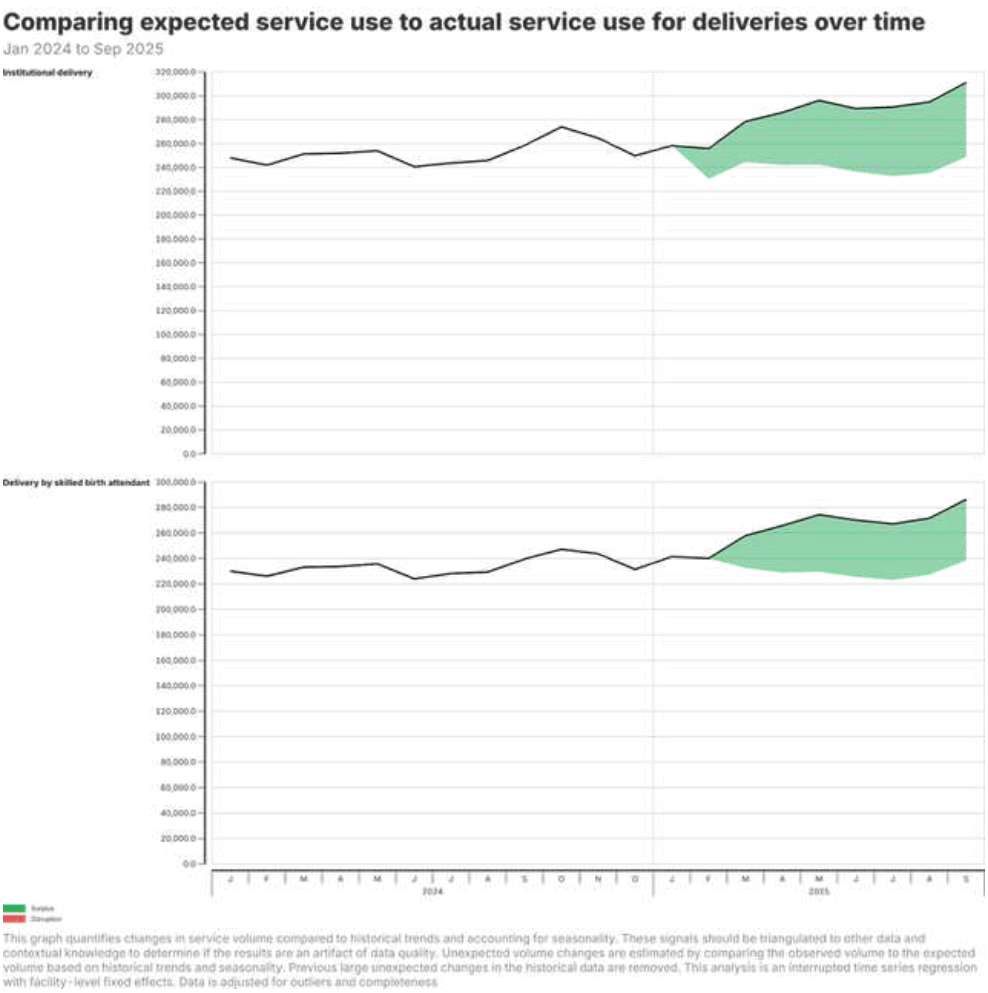


Figure 35

Observed and Expected Trends in Institutional Deliveries and Skilled Birth Attendance, Nigeria, January 2024–September 2025

Between January 2024 and September 2025, both institutional deliveries and deliveries attended by skilled birth attendants (SBAs) showed notable deviations from expected service use patterns. At the beginning of 2024, observed volumes for both indicators were below the expected range based on historical trends and seasonality. However, utilization increased steadily throughout 2024 and into 2025, surpassing expected levels by mid-2025.

For institutional deliveries, the observed service volume rose consistently, moving from below the expected range in early 2024 to above the expected range by the second half of 2025. A similar pattern was observed for SBA coverage, with actual volumes initially lagging behind expectations but later exceeding projected levels.

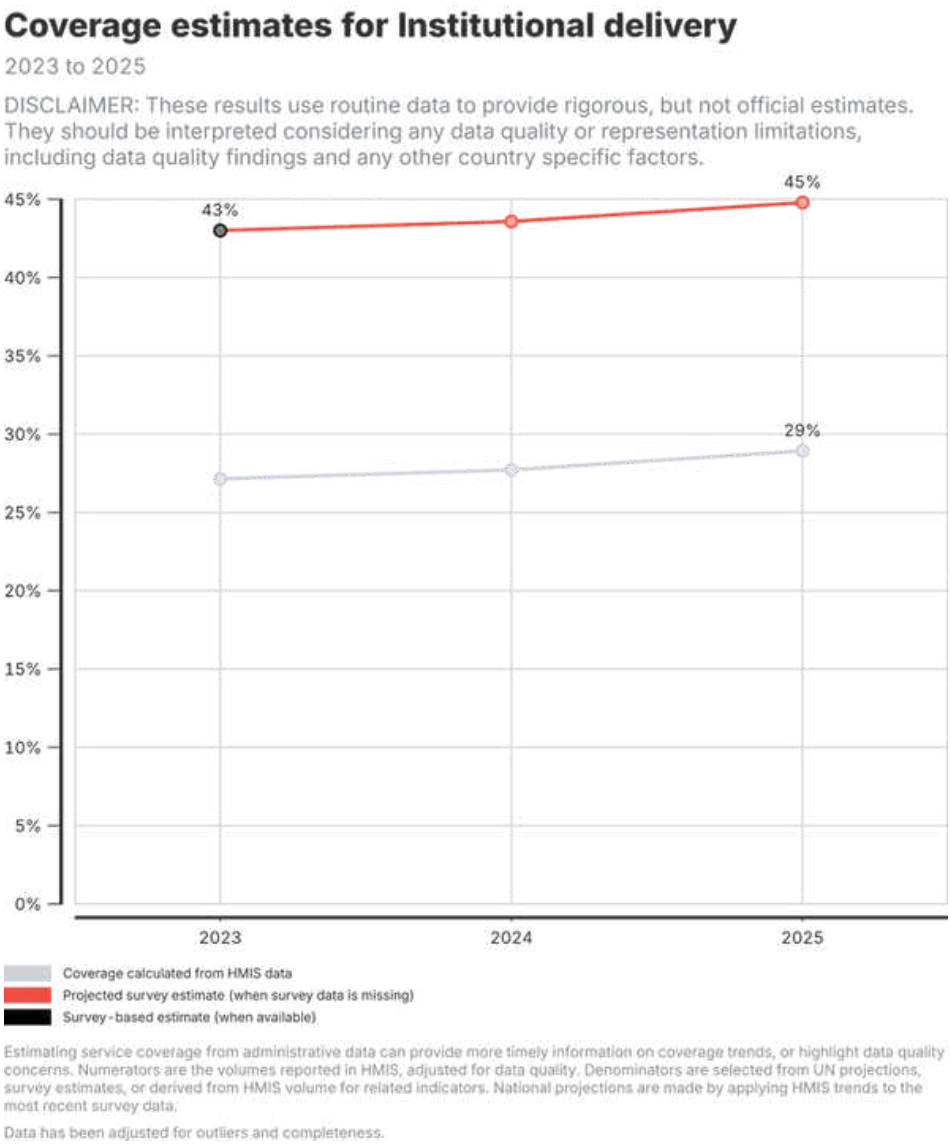


Figure 36

Institutional Delivery Coverage Estimates, Nigeria, 2023–2025

Institutional delivery coverage remained stable between 2023 and 2025. Coverage calculated from HMIS data rose from 25% to 29% across the three years, while projected survey estimates were slightly higher at 45%. The close trend alignment between HMIS and projected survey estimates suggests consistency in reporting, with delivery coverage during the period.

Deliveries monitored with a partograph

Nationally, the percentage of reported deliveries monitored with a partograph in 2025 is 75.7%. Both deliveries and partograph usage is increasing at the same rate; therefore, the percentage of births monitored with a partograph has been stable across all quarters of 2025.

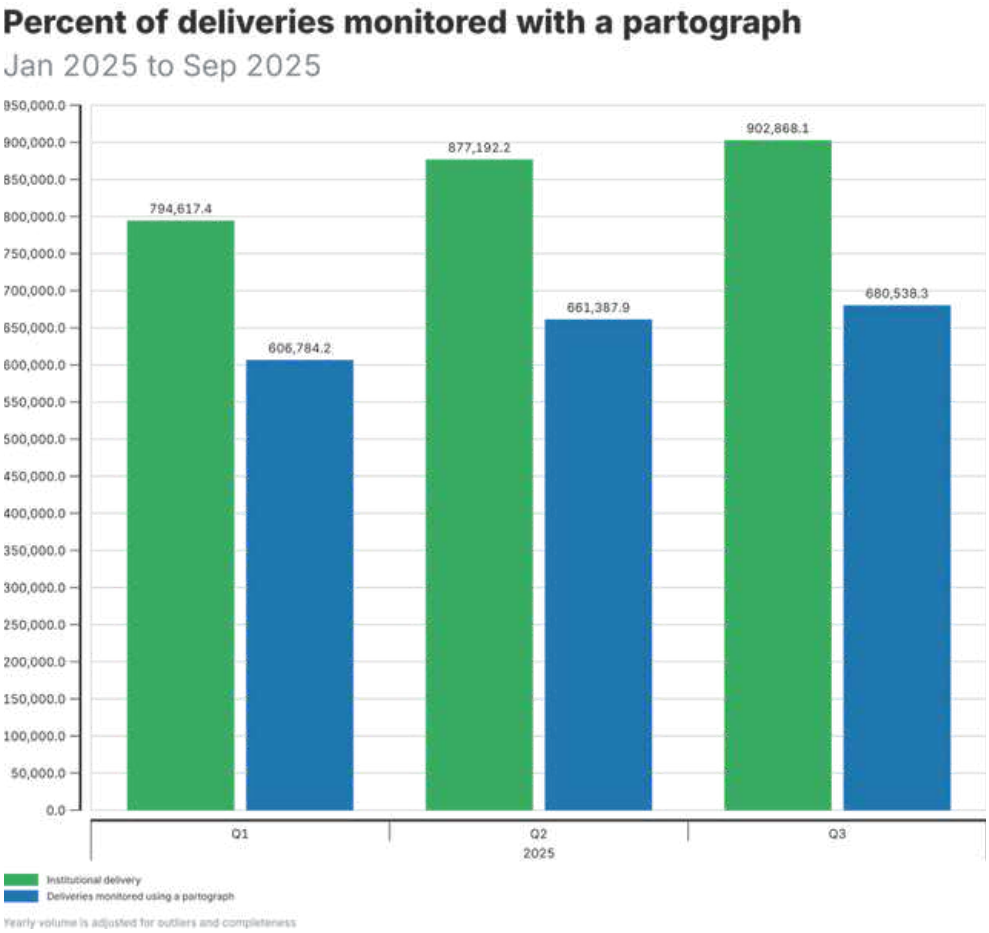


Figure 37

Institutional Deliveries and Use of Partograph, Nigeria, January–September 2025

Between January and September 2025, both institutional deliveries and the use of partographs during labor showed steady increases. Institutional deliveries rose from 794,617 in the first quarter to 902,868 in the third quarter. Over the same period, the number of deliveries monitored with a partograph increased from 606,784 to 689,538. Although the use of partographs expanded in line with rising institutional deliveries, the proportion of deliveries monitored with this tool remained lower than the total number of institutional births.

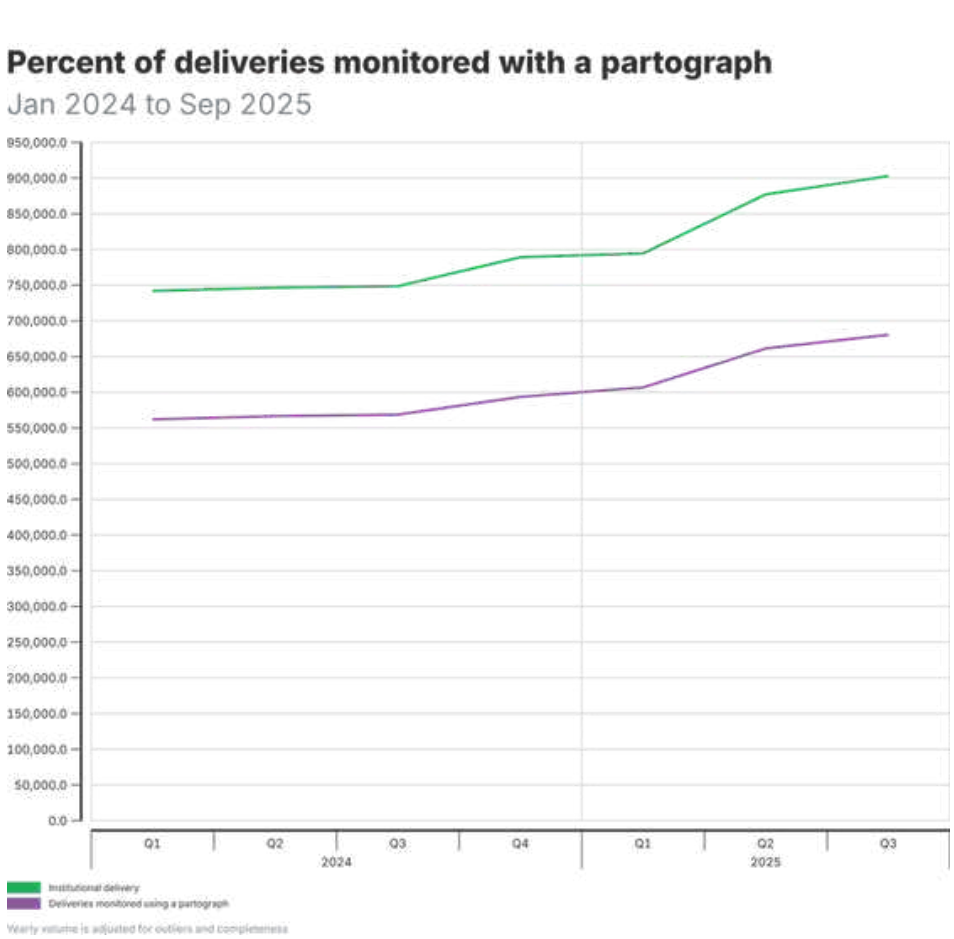


Figure 38

Institutional Deliveries and Use of Partograph, Nigeria, January 2024–September 2025

Between January 2024 and September 2025, both institutional deliveries and the use of partographs during labor showed steady increases. Institutional deliveries rose consistently across the period, while the number of deliveries monitored with a partograph also increased but remained below the total number of institutional births.

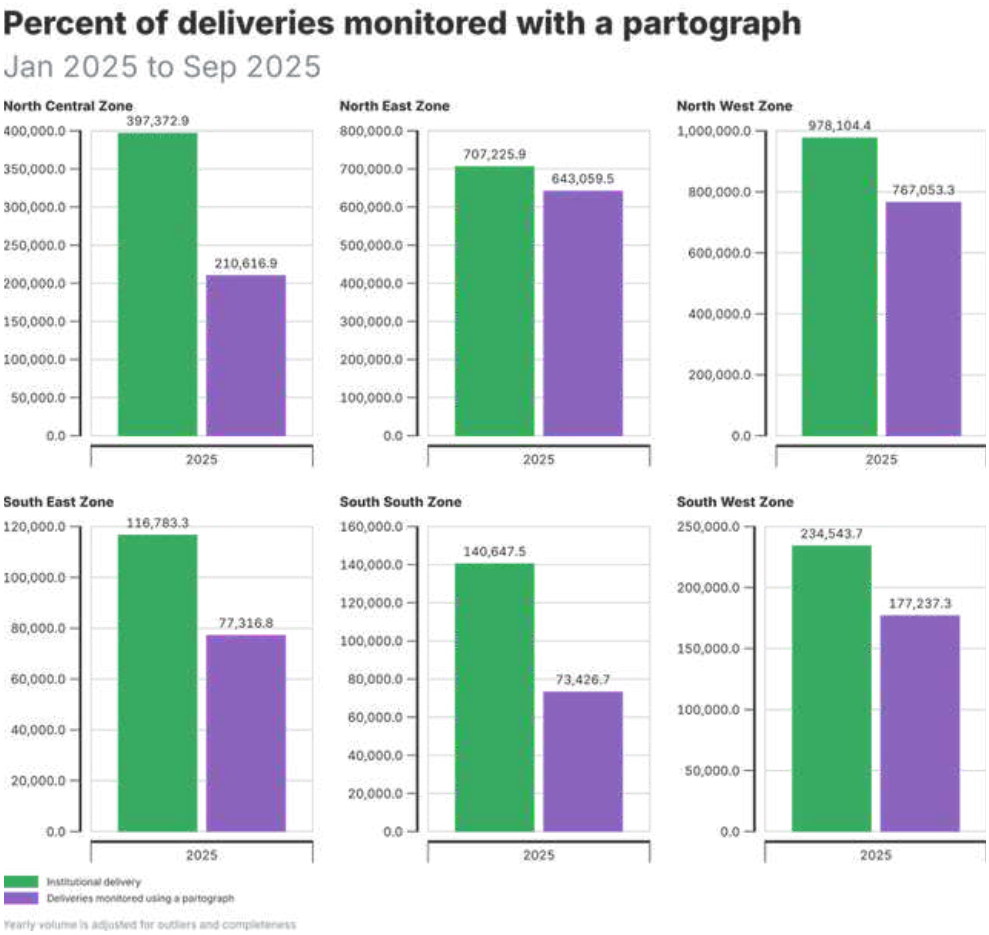


Figure 39

Institutional Deliveries and Use of Partograph by Geopolitical Zone Nigeria, January 2025 to September 2025

Between January and September 2025, the proportion of institutional deliveries monitored with a partograph varied across zones. The North-West recorded the highest volumes, followed by Nort- East with over 700,000 institutional deliveries and 643,000 monitored. In the North-Central zone, about half of institutional deliveries were monitored with a partograph. In the South-East and South-South zones, institutional deliveries were lower. The South-West zone recorded 235,000 institutional deliveries, of which 177,000 were monitored. Overall, northern zones reported higher absolute volumes, while the proportion of deliveries monitored with a partograph was consistently lower than total institutional deliveries in all zones.

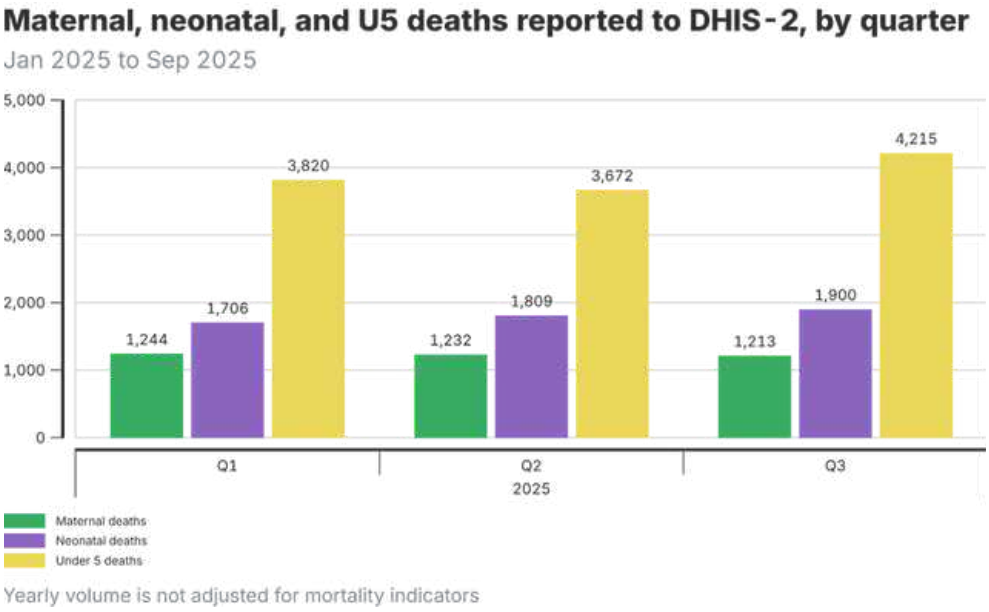


Figure 40

Maternal, Neonatal, and Under-Five Deaths Reported to DHIS-2, Nigeria, January–September 2025

Between January and September 2025, reported maternal, neonatal, and under-five deaths showed modest fluctuations across quarters. Maternal deaths declined slightly from 1,244 in Q1 to 1,213 in Q3. Neonatal deaths increased from 1,706 in Q1 to 1,900 in Q3, while under-five deaths increased from 3,820 in Q1 to 3,672 in Q2 before rising to 4,215 in Q3. Overall, maternal deaths showed a gradual decline, neonatal deaths rose steadily, and under-five deaths increased notably in Q3.

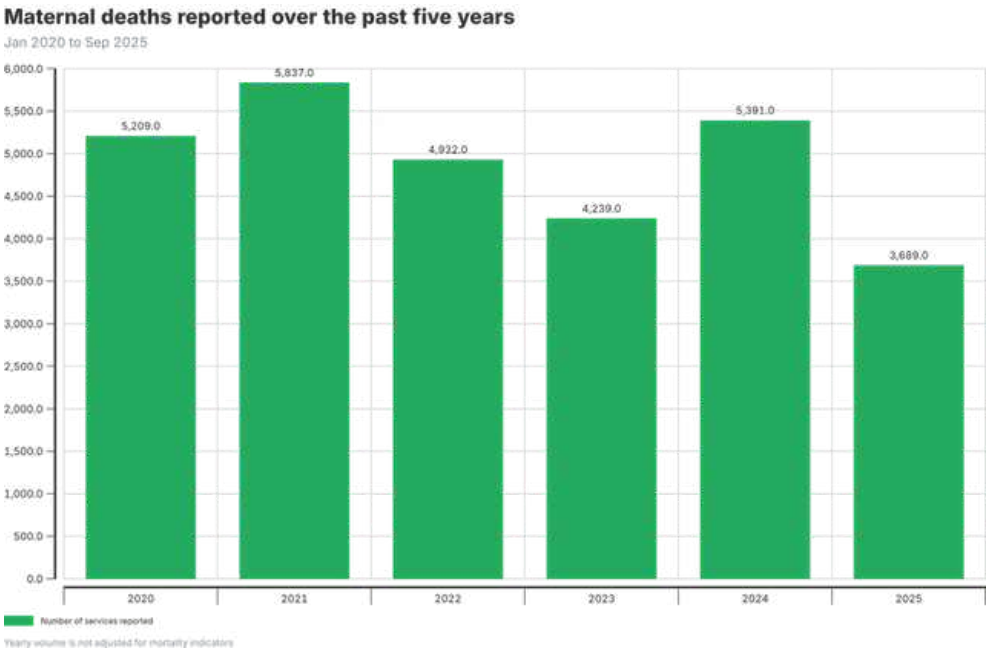


Figure 41

Maternal Deaths Reported, Nigeria, 2020–2025

Reported maternal deaths fluctuated between 2020 and 2025. The highest number was recorded in 2021 (5,987), followed by 2024 (5,391). The lowest number was reported in 2025 (3,889), representing a decline from 5,208 in 2020.

Neo-natal and Child Health

% of live births that received BCG	66% (6,128,620)
Penta 3 coverage (Penta 3 given)	6,334,644
% of children 0–11 months fully immunized	61%
% of children 12–23 months fully immunized	43%
Fully immunized children under 1 year	5,680,884
Number of zero-dose children vaccinated	288,248
% of children with zero-dose	28%
% of children 6 weeks–23 months yet to receive Penta 1	26%
Neonatal mortality rate	41 per 1,000 (NDHS 2024)
Infant mortality rate	7.4% (DHIS2, as at 4th Nov. 2025)

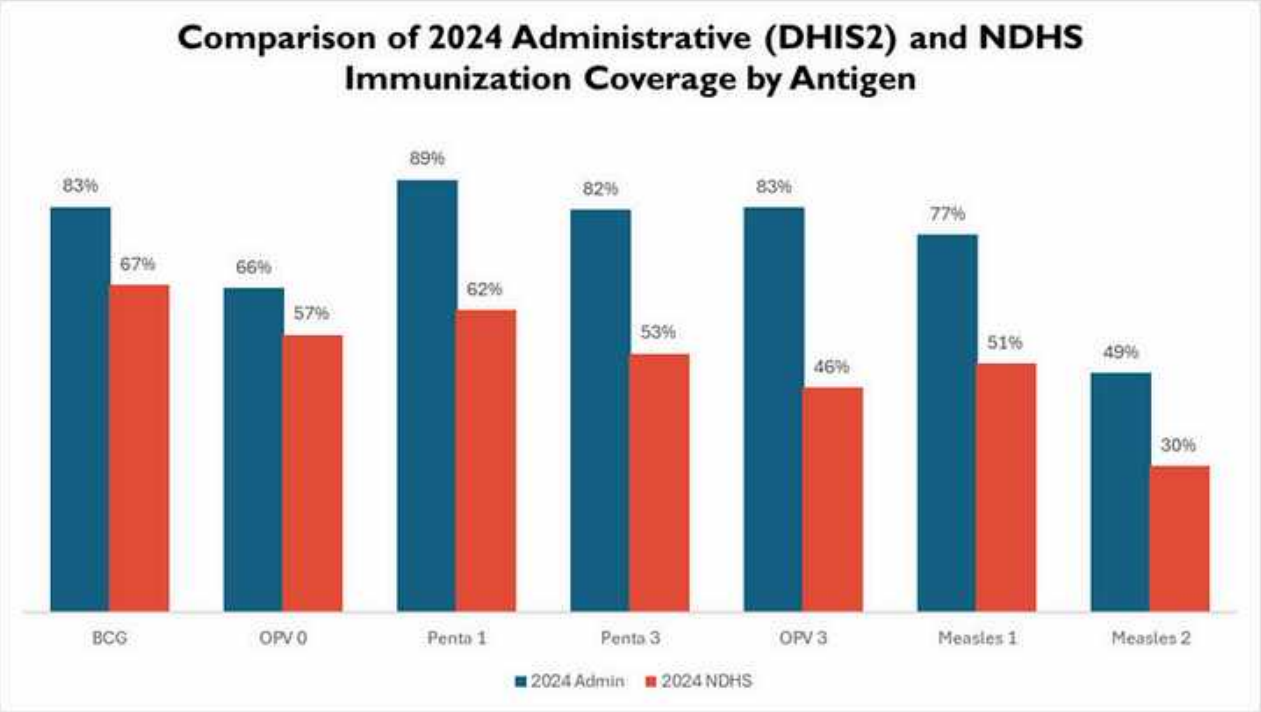


Figure 42: 2024 Immunization Coverage: Admin Data vs. NDHS

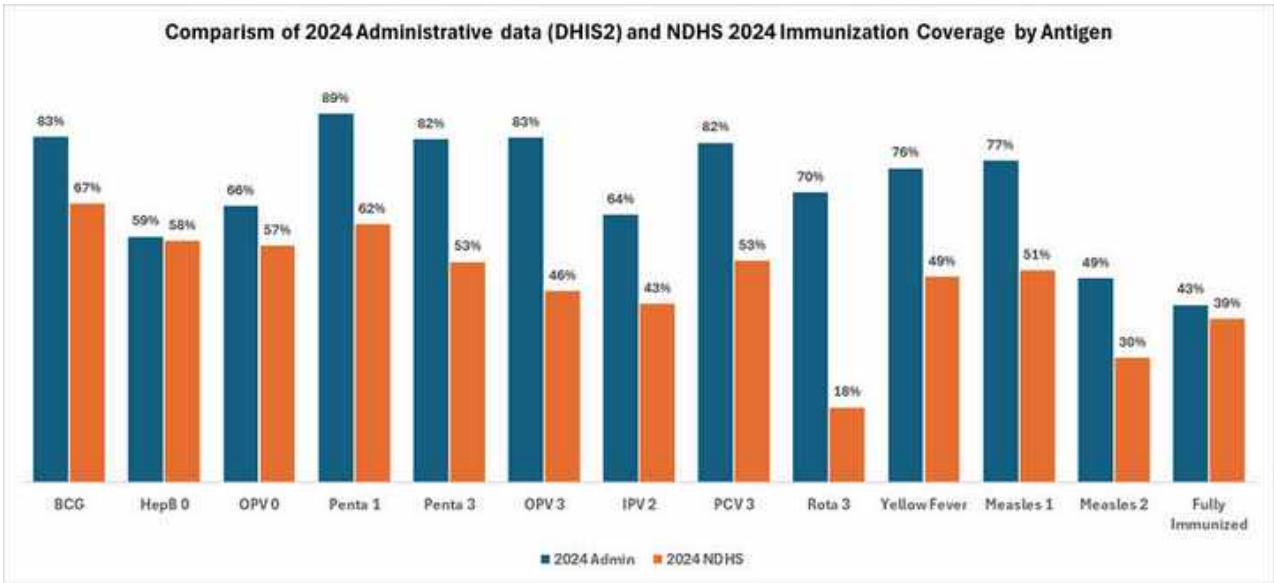


Figure 43: Immunization Coverage: Admin Data 2024 vs. NDHS 2024

Figure 42 & 43 shows that administrative coverage rates for all antigens are consistently higher than those reported in the 2024 DHS, with the largest gaps seen for Penta 3, OPV 3, and Measles 2. Fully immunized data indicates a relatively small difference of 4%, suggesting closer agreement between the two data sources for full immunization compared to most individual antigens.

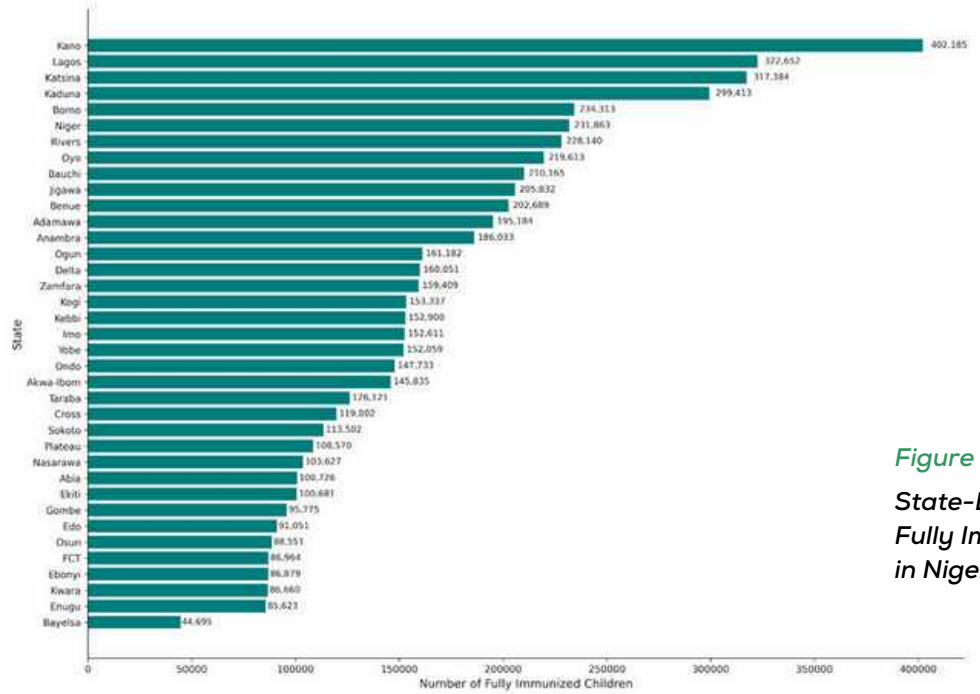


Figure 44

State-Level Distribution of Fully Immunized Children in Nigeria

Source *FASTR Adjusted DHIS2 Data 2025*

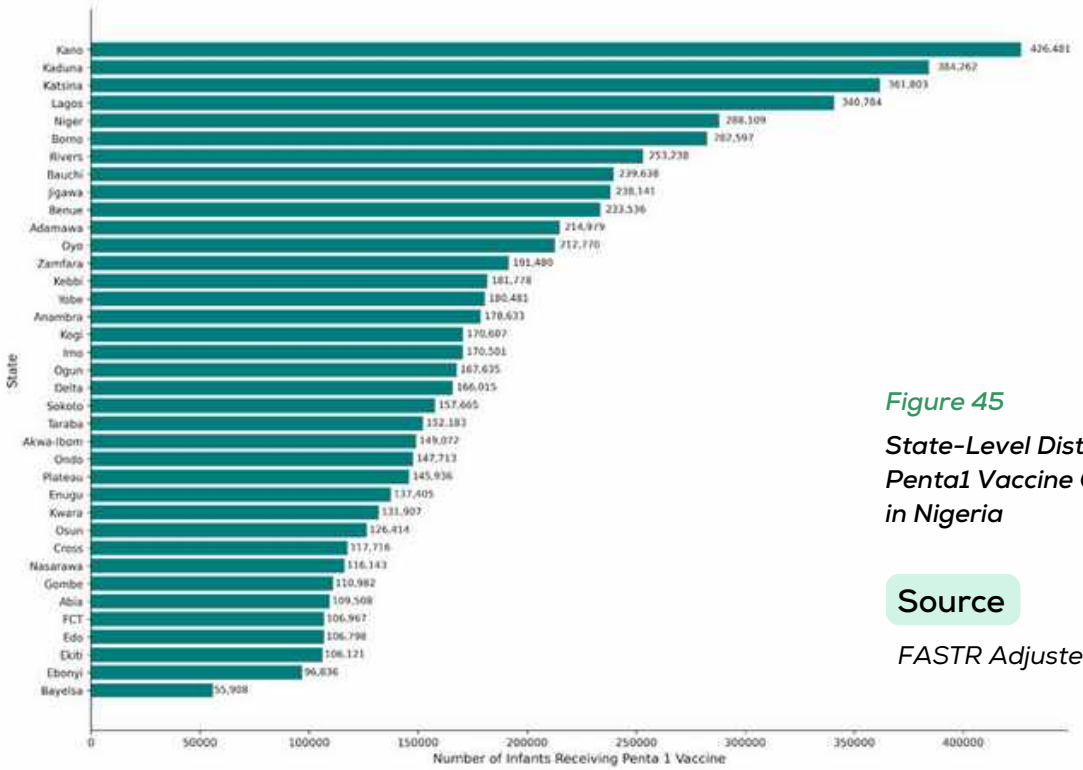


Figure 45

State-Level Distribution of Penta1 Vaccine Coverage in Nigeria

Source

FASTR Adjusted DHIS2 Data 2025

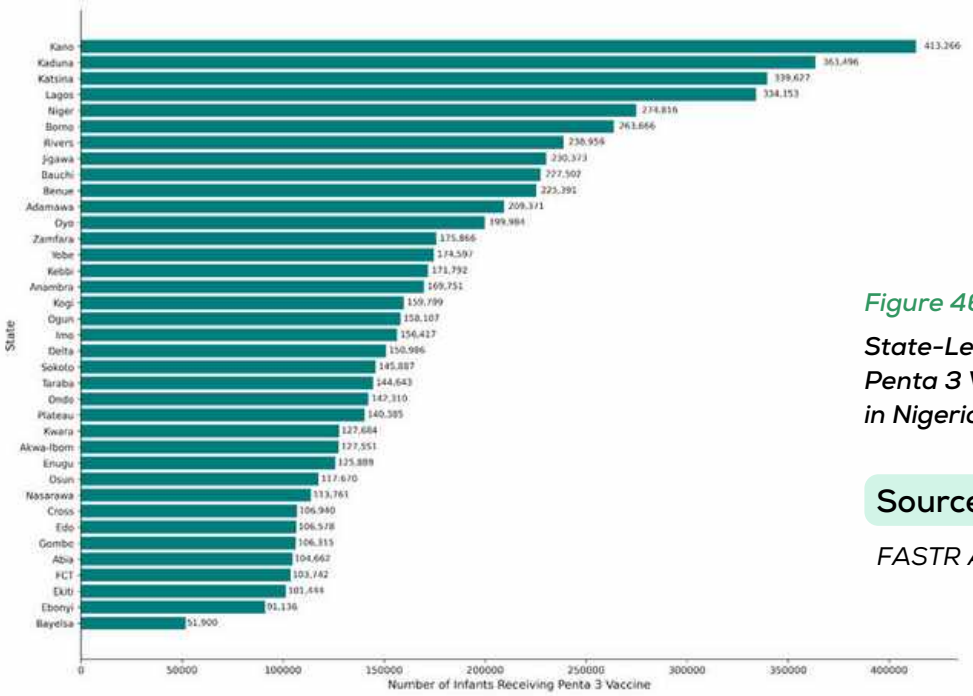


Figure 46

State-Level Distribution of Penta 3 Vaccine Coverage in Nigeria

Source

FASTR Adjusted DHIS2 Data 2025

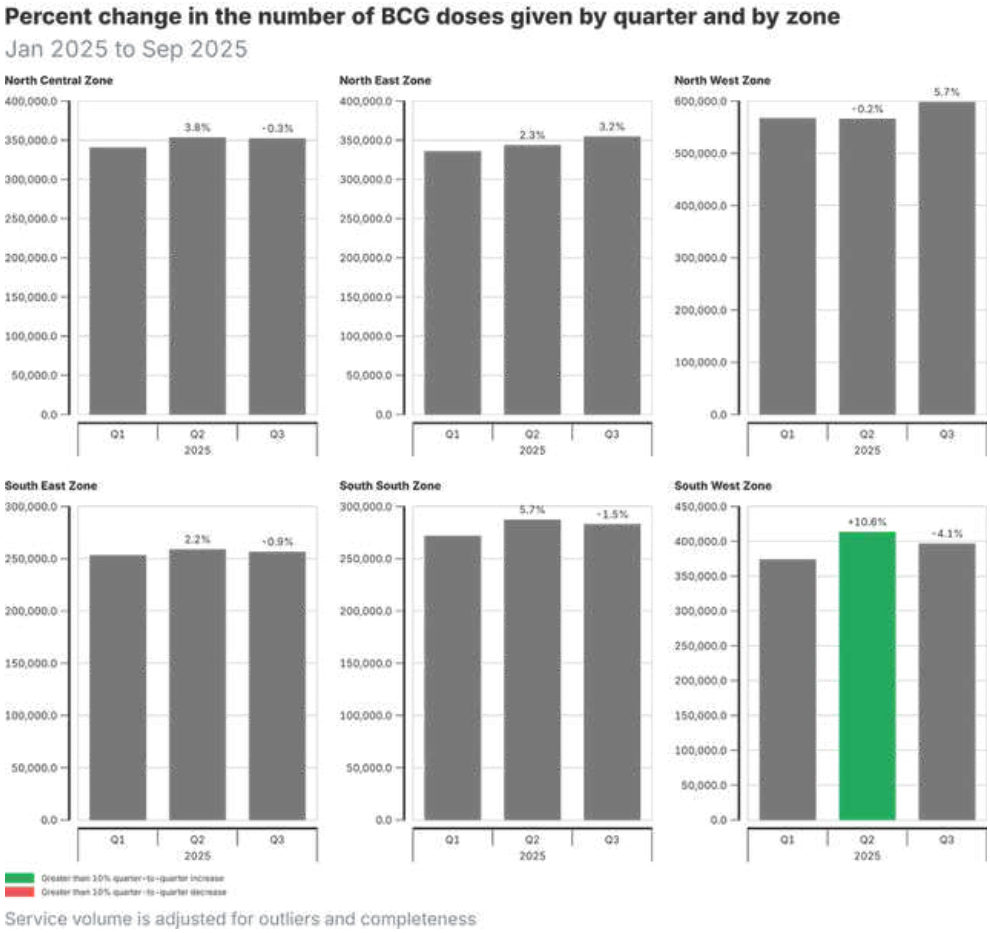


Figure 47

Percent Change in BCG Doses Given by Geopolitical Zone and Quarter, Nigeria, January–September 2025

Between January and September 2025, the percentage change in BCG doses given varied across zones and quarters. In the North-Central and North-West zones, coverage increased by 3.2% in both Q2 and Q3, while the North-East recorded a smaller increase of 2.3% over the same period. In contrast, the South-East and South-South zones experienced declines, with reductions of 9.0% and 5.1%, respectively, in both Q2 and Q3. The South-West zone showed the largest quarterly fluctuation, with an increase of 10.6% in Q2 followed by a decline of 4.1% in Q3. Overall, northern zones recorded modest positive changes, while southern zones showed mixed or negative trends.

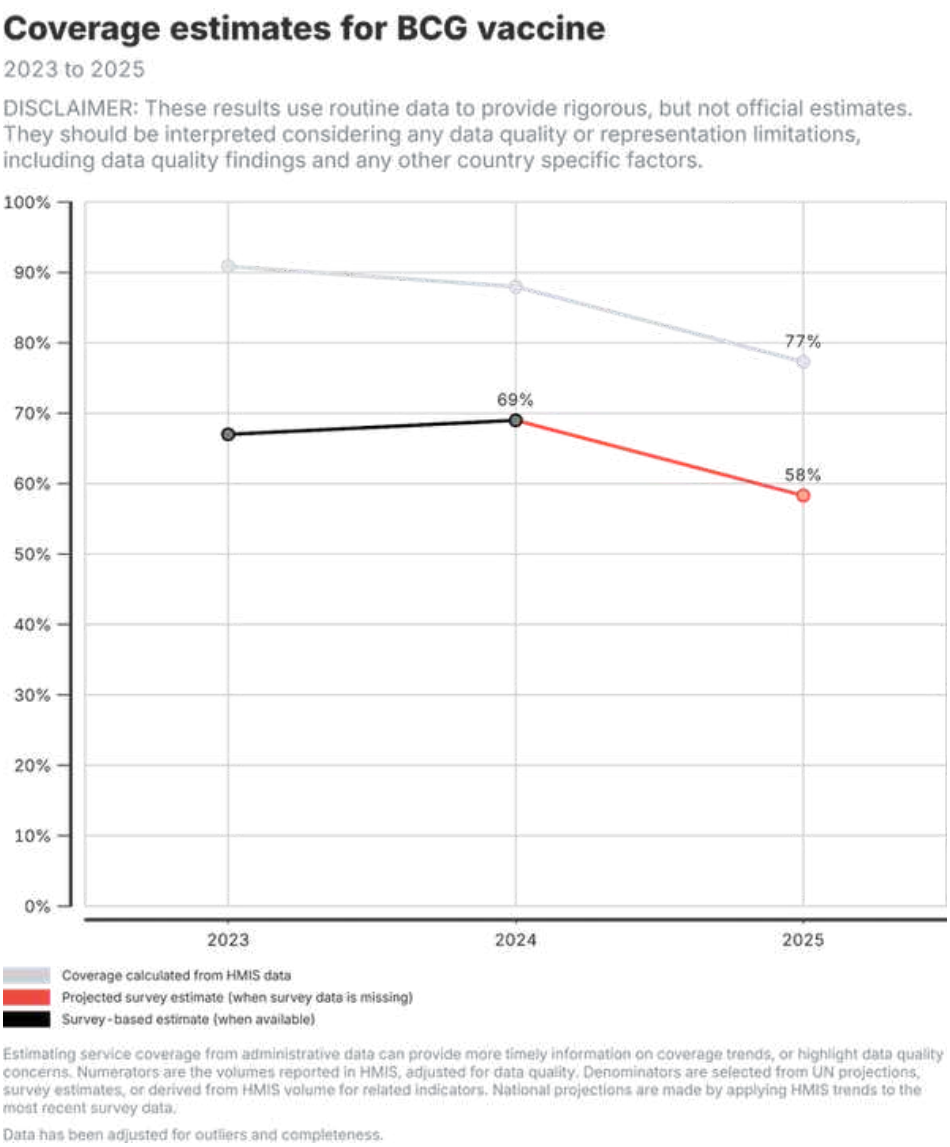


Figure 48

BCG Vaccine Coverage Estimates from HMIS and Survey. Between 2023 and 2025

BCG vaccine coverage is estimated to have declined. Coverage calculated from HMIS data is consistently higher than survey estimates, with a high of 90% in 2023 falling to 77% in 2025. Survey-based estimates, available in 2024, were lower at 69% and projected survey estimates in 2025 have fallen to 58%. This projected decrease in BCG coverage is due to both a decrease in BCG doses given in the numerator and an increase in projected live births in the denominator.

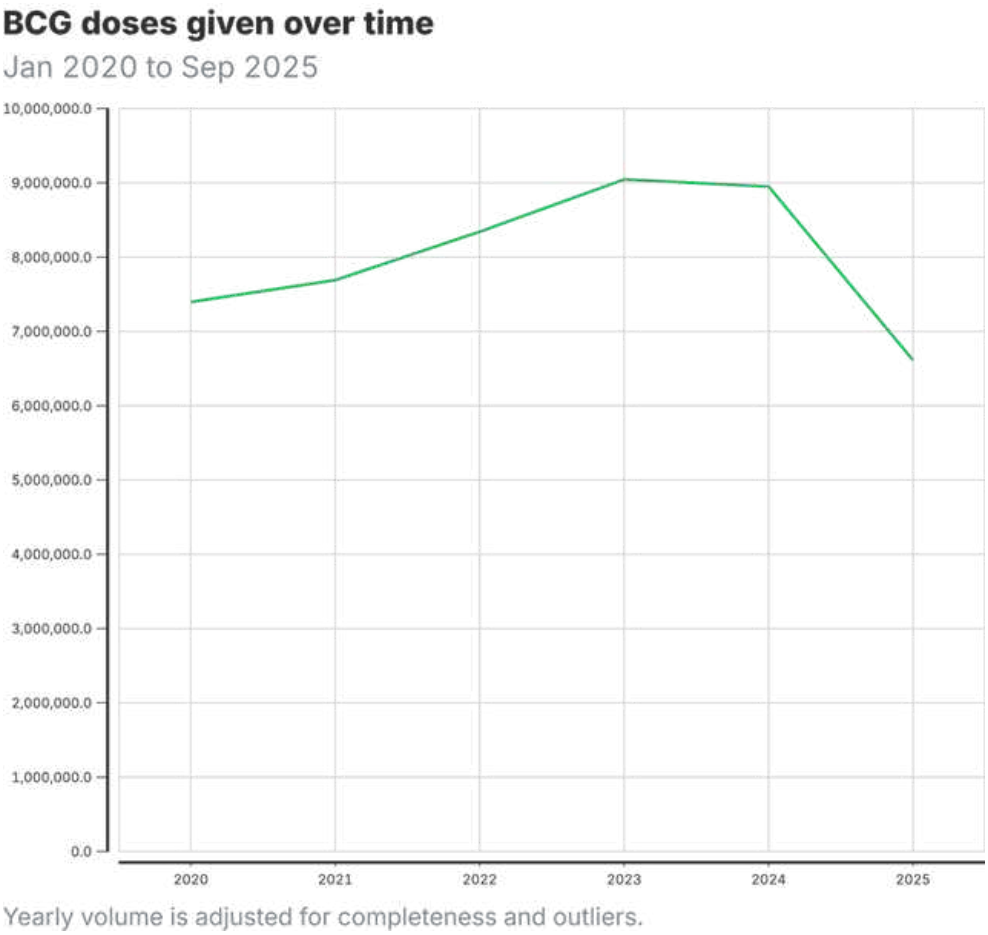


Figure 49

BCG Doses Administered, Nigeria, 2020–September 2025

The number of BCG doses administered increased steadily from 2020 to 2023, peaking at about 9 million doses in 2023. Coverage declined in 2024 to approximately 7 million doses and continued to decrease in 2025, though data for 2025 reflect only the period from January to September.

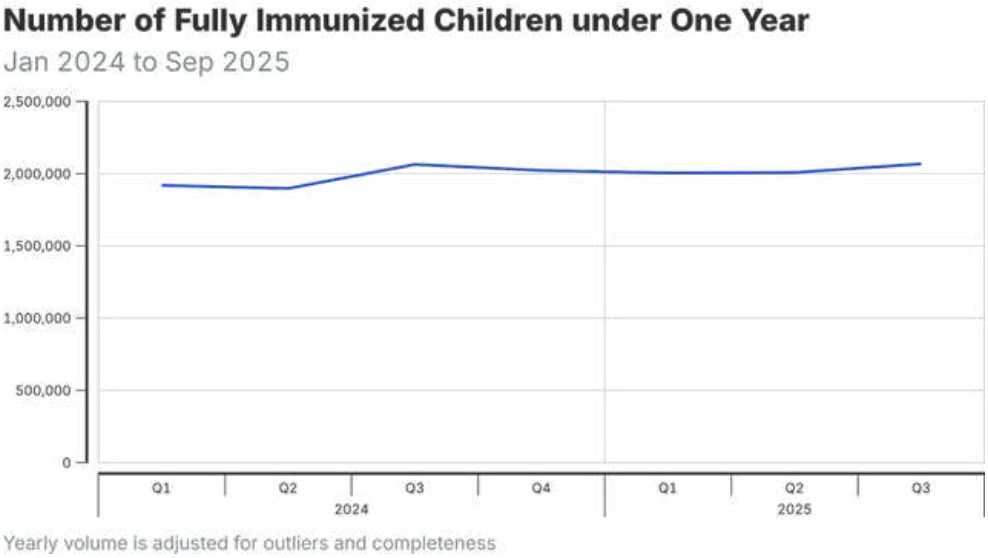


Figure 50

Number of Fully Immunized Children Under One Year Nigeria, January 2024–September 2025

Between January 2024 and September 2025, the number of fully immunized children under one year remained relatively stable at around 2 million per quarter. Minor fluctuations were observed across quarters, but no significant upward or downward trend was evident.

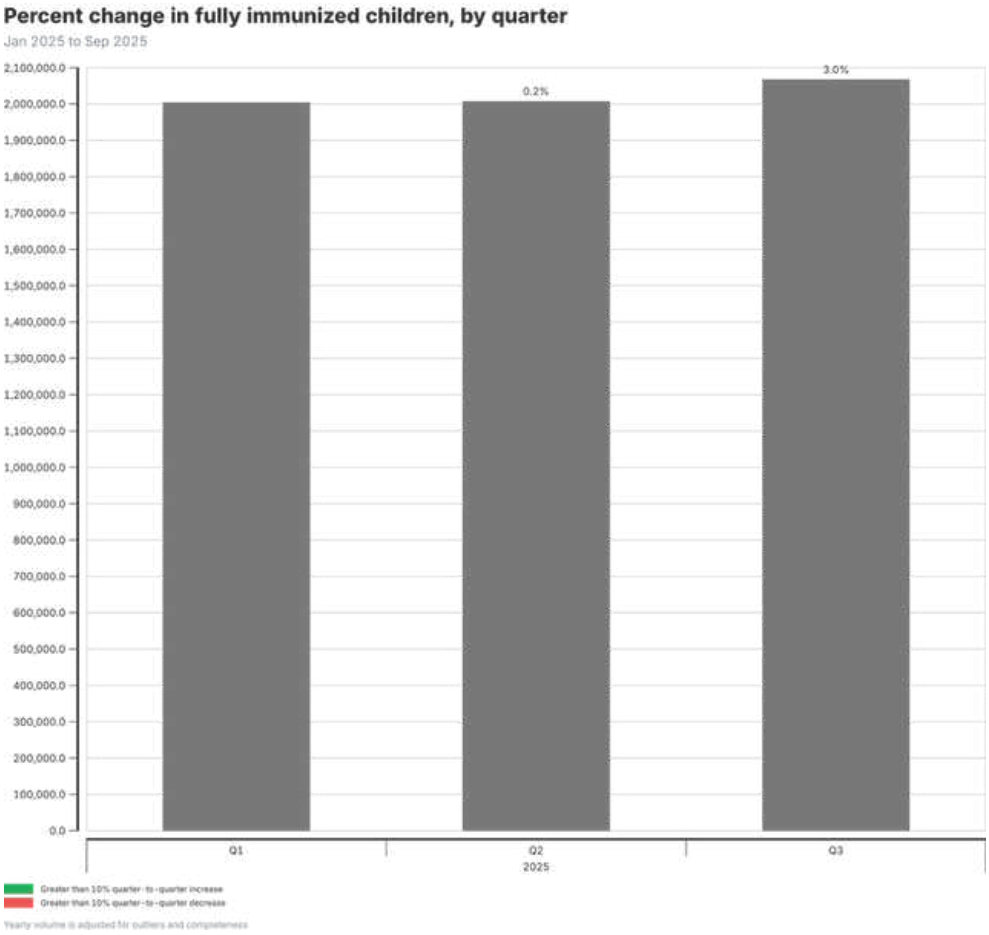


Figure 51

Percent Change in Fully Immunized Children, Nigeria, January–September 2025

Between January and September 2025, the percent change in the number of fully immunized children under one year remained positive but modest. Increases of 2.0% were recorded in Q1 and Q3, while Q2 showed only a slight increase of 0.2%. Overall, the data indicate stable but limited quarterly growth in full immunization coverage during the period.

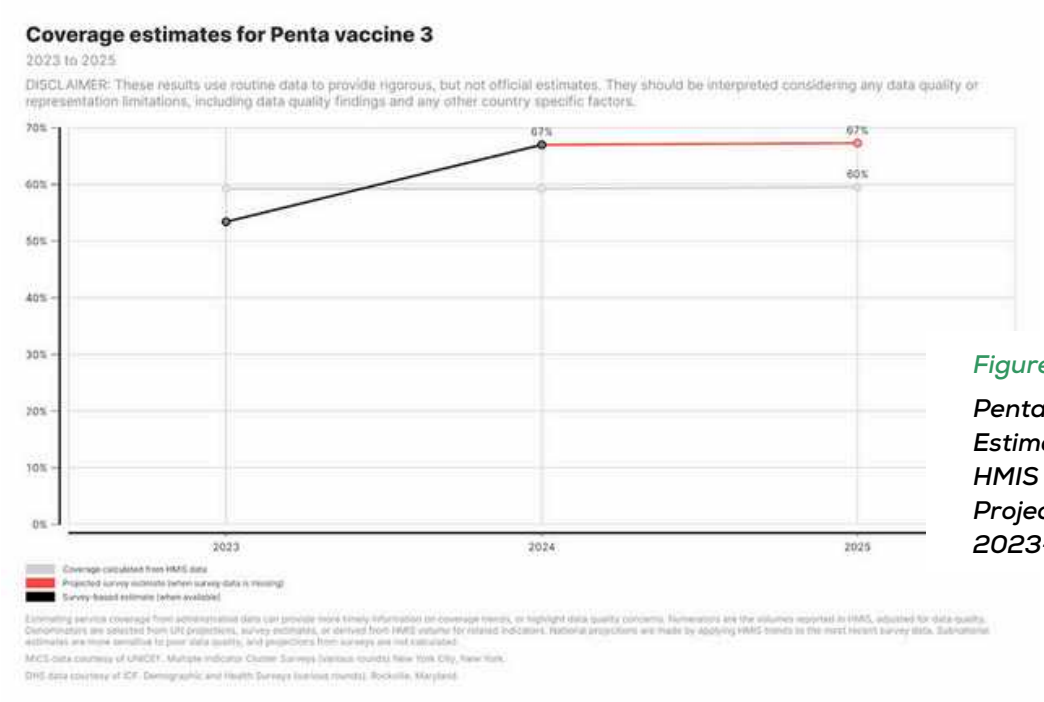


Figure 52

Penta 3 Coverage Estimates from HMIS and Projections, Nigeria, 2023–2025

Between 2023 and 2025, Penta 3 coverage estimates varied depending on the data source. HMIS data indicated coverage of 60% from 2023 to 2025. Projected survey estimates, however, remained a bit higher at 67% in both 2024 and 2025. Overall, these projections suggest stable coverage.

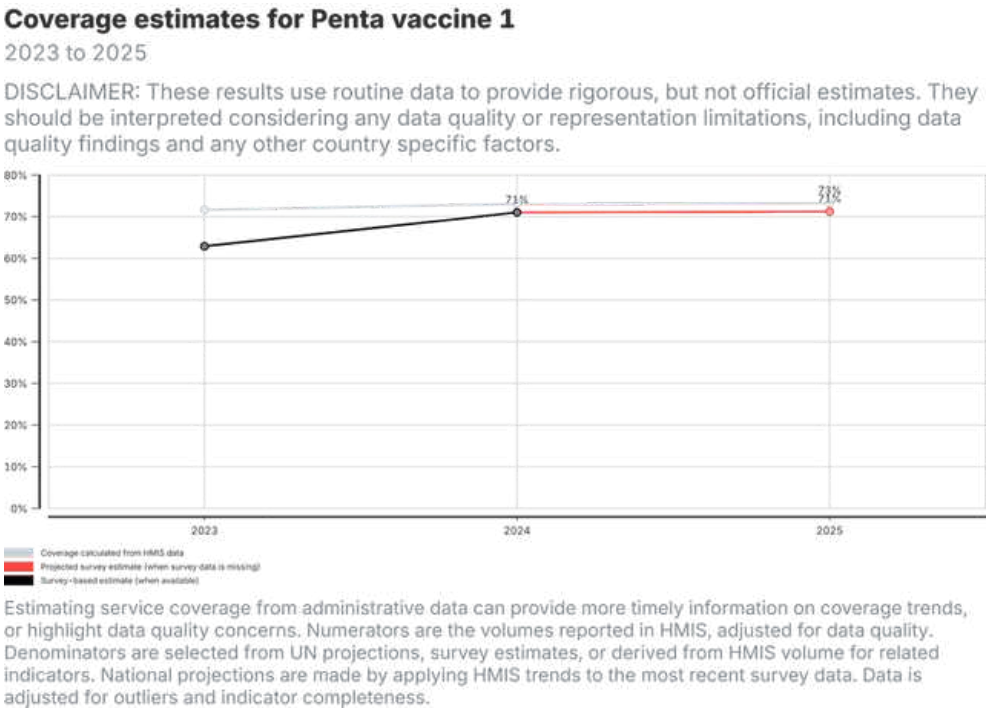


Figure 53

Penta 1 Coverage Estimates, Nigeria, 2023–2025

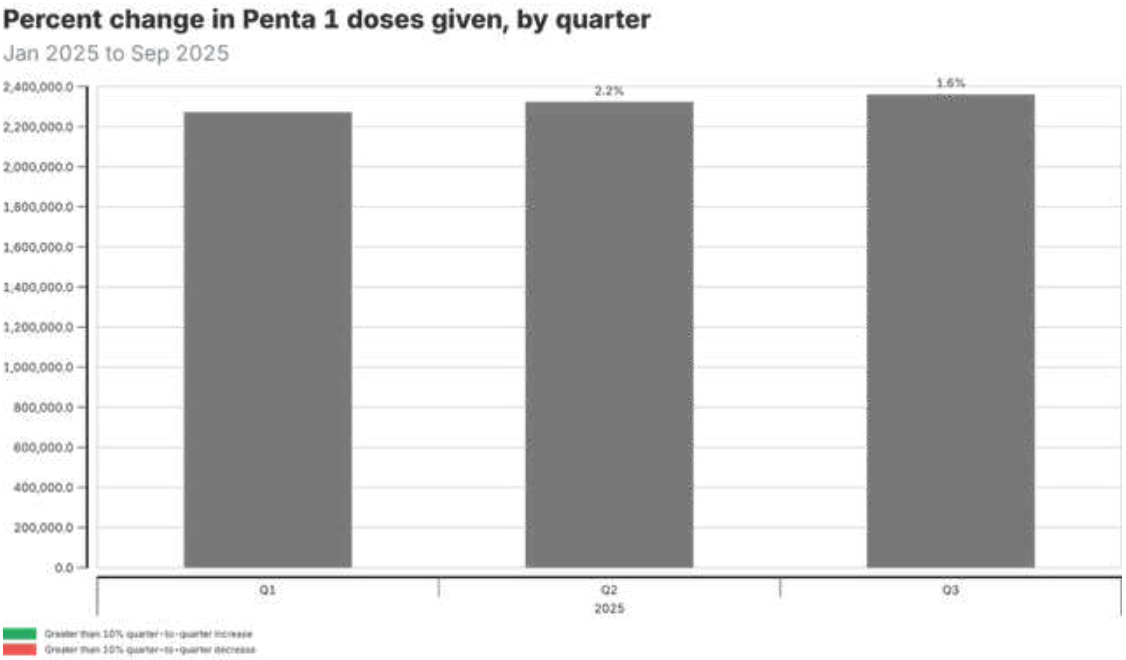


Figure 54

Penta 1 Doses Administered by Geopolitical Zone and Quarter, Nigeria January–September 2025

Between January and September 2025, the number of Penta 1 doses administered increased slightly across quarters. Doses rose from about 2.2 million in Q1 to nearly 2.3 million in Q2, representing a 2.2% increase, and continued to rise modestly in Q3 with a 1.6% increase. No quarter recorded a change greater than 10%. Overall, the data indicate stable but gradual growth in Penta 1 administration during the period.

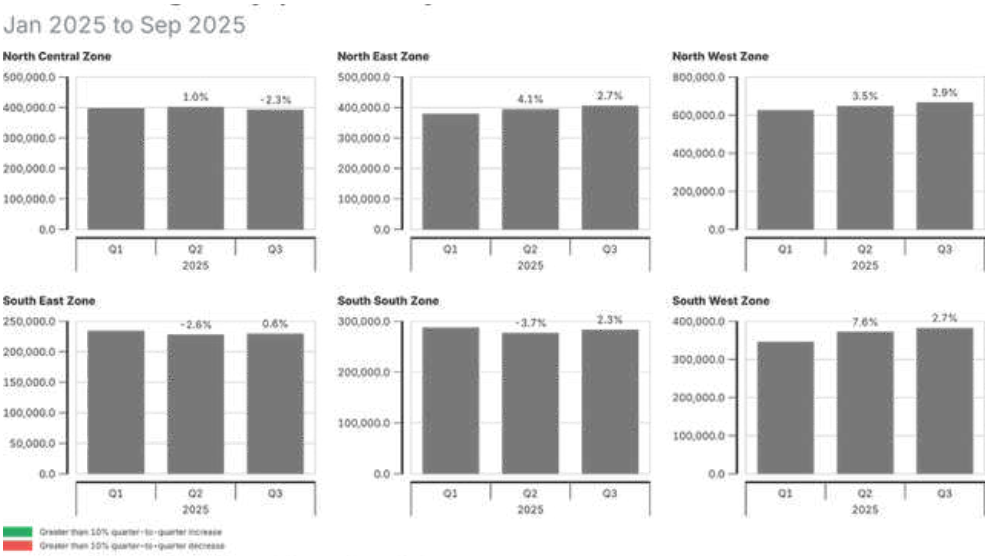


Figure 55

Penta 1 Doses Administered by Geopolitical Zone and Quarter, Nigeria January–September 2025

Between January and September 2025, the number of Penta 1 doses administered showed modest quarterly changes across all zones. From Q1 to Q2, most zones recorded small increases, ranging from 1.0% in North Central to 7.6% in the Southwest. From Q2 to Q3 performance was mixed.

Nutrition

Number of children 6–59 months reached with Vitamin A supplementation	42,449,039
Number of children 6–23 months who received Micronutrient Powder	433,447
Number of under-5 children admitted for Severe Acute Malnutrition (SAM) treatment	439,200

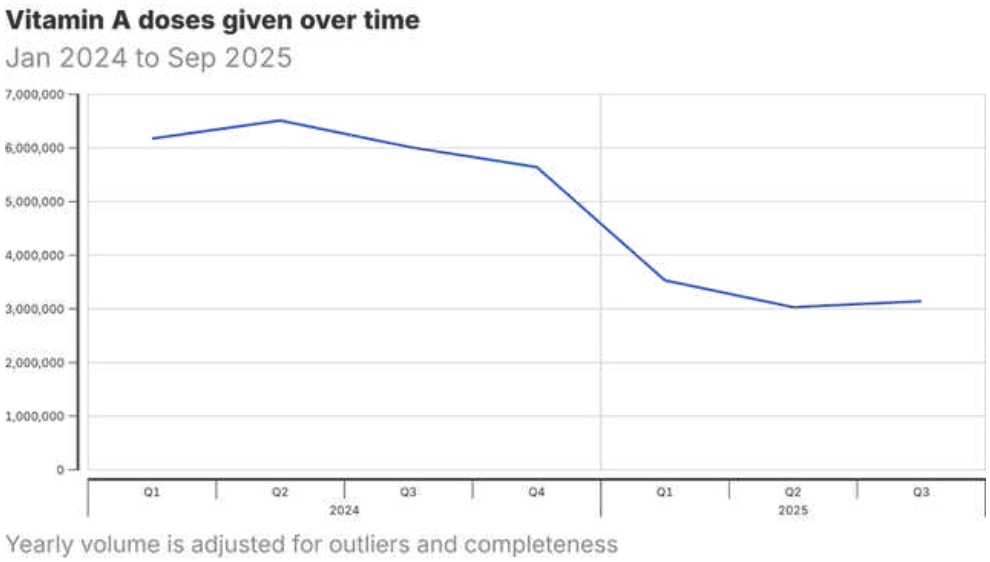
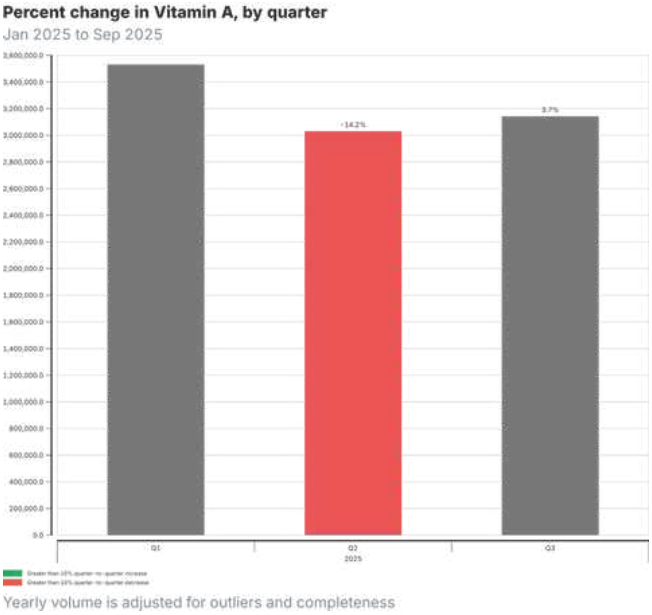


Figure 56

Percent Change in Vitamin A Doses Administered, Nigeria

Between January 2024 and September 2025, the number of Vitamin A doses administered declined substantially. Doses were highest in Q1 2024 at nearly 7 million, followed by gradual decreases in Q2 and Q3 and a sharp drop in Q4 2024. From Q1 to Q3 2025, the number of doses stabilized at around 3 million per quarter. Overall, the data indicate a marked reduction in Vitamin A administration after 2024, with lower but steady levels maintained in 2025.



Between January and September 2025, Vitamin A administration fluctuated markedly. A sharp decline of 14.7% was recorded in Q2, following a positive level in Q1. In Q3, coverage rebounded with a 9.7% increase, though the recovery did not fully offset the earlier decline. Overall, the data indicate instability in Vitamin A administration during the period, with a notable drop in Q2 followed by partial recovery in Q3.

Figure 57

Percent Change in Vitamin A Doses Administered, Nigeria

Figure 58

Vitamin A Doses Administered by Geopolitical Zone and Quarter Nigeria, January–September 2025

Between January and September 2025, Vitamin A administration declined across zones. Declines greater than 10% were observed in the North-East (–5.9% from Q1 to Q2), North-West (–10.9% from Q2 to Q3), South-East (–12.5% from Q1 to Q2), South-South (-24.1% from Q1 to Q2) and South-West (–2.6% from Q2 to Q3). Overall, the data indicates sharp decreases across zones, with only North-Central showing any signs of minor recovery.

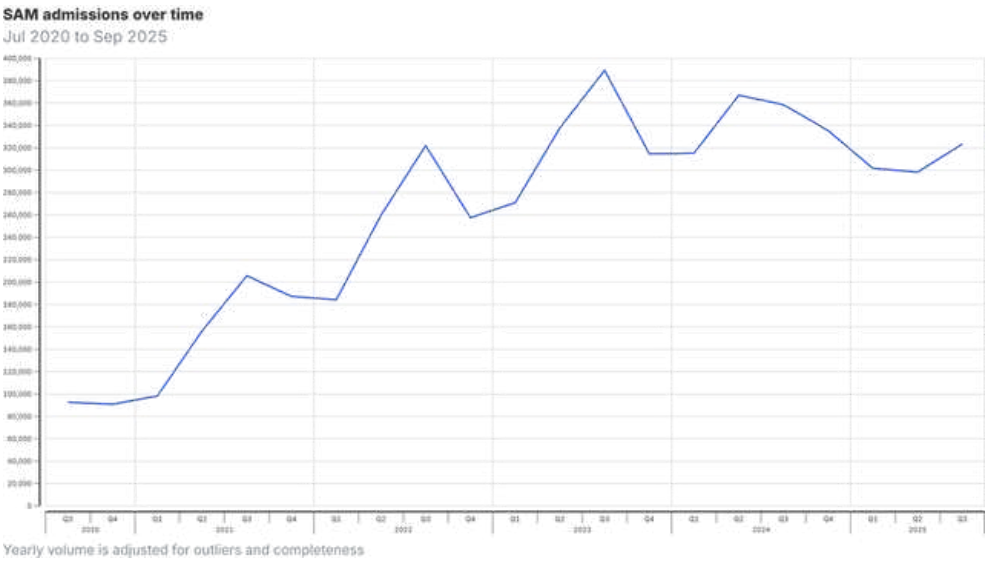


Figure 59

Severe Acute Malnutrition (SAM) Admissions, Nigeria July 2020–September 2025

Between July 2020 and September 2025, admissions for severe acute malnutrition (SAM) showed an overall upward trend with notable fluctuations. Admissions rose sharply in early 2022 and early 2023, peaking at nearly 350,000 cases. Declines were observed in mid-2023 and mid-2024, followed by renewed increases. By 2025, admissions remained elevated, indicating sustained high admissions for severe acute malnutrition

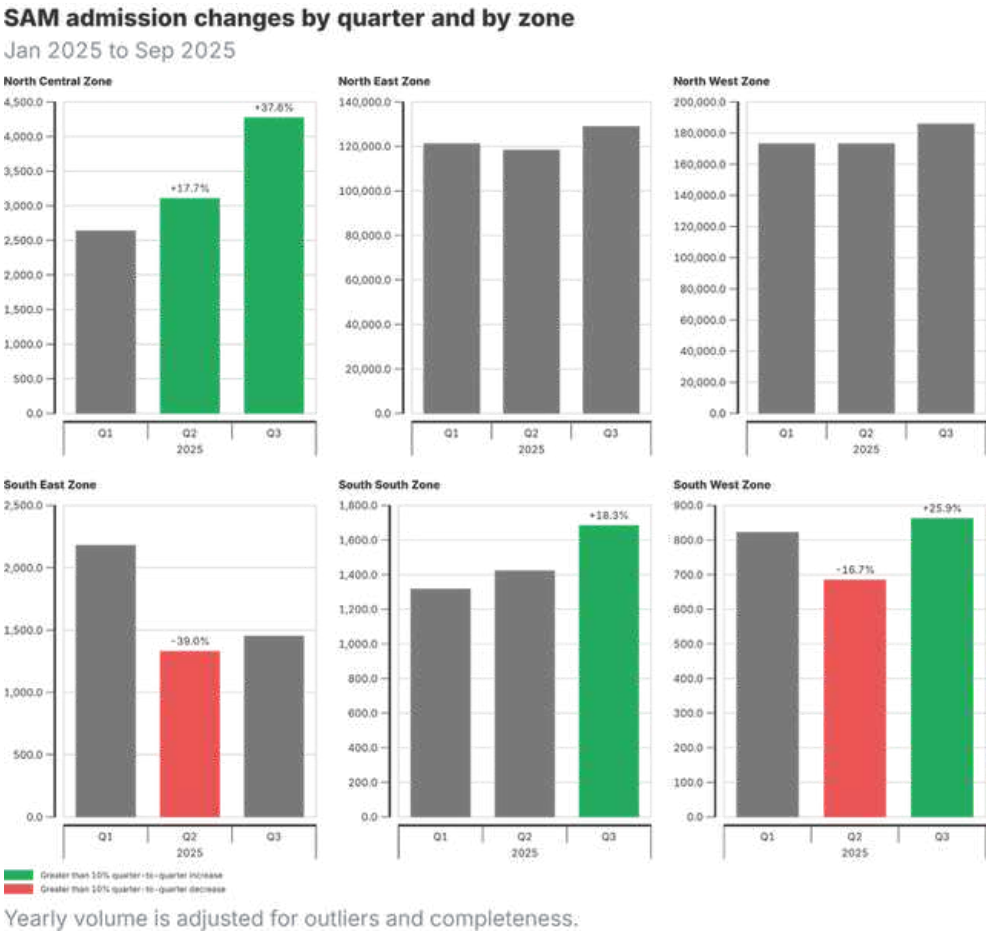


Figure 60

Severe Acute Malnutrition (SAM) Admissions by Geopolitical Zone and Quarter, Nigeria, January–September 2025

Between January and September 2025, changes in SAM admissions varied widely across zones. Admissions increased by 17.7% in the North-Central zone, while the North-East and North-West remained largely stable. In contrast, the South-East, South-South, and South-West zones recorded substantial declines, with reductions of 30.0%, 18.3%, and 10.7%, respectively. Overall, the data indicates divergent regional patterns, with increases in the North Central but marked decreases across southern zones.

Between January and September 2025, changes in SAM admissions varied widely across zones. Admissions increased by 17.7% in the North-Central zone, while the North-East and North-West remained largely stable. In contrast, the South-East, South-South, and South-West zones recorded substantial declines, with reductions of 30.0%, 18.3%, and 10.7%, respectively. Overall, the data indicates divergent regional patterns, with increases in the North Central but marked decreases across southern zones.

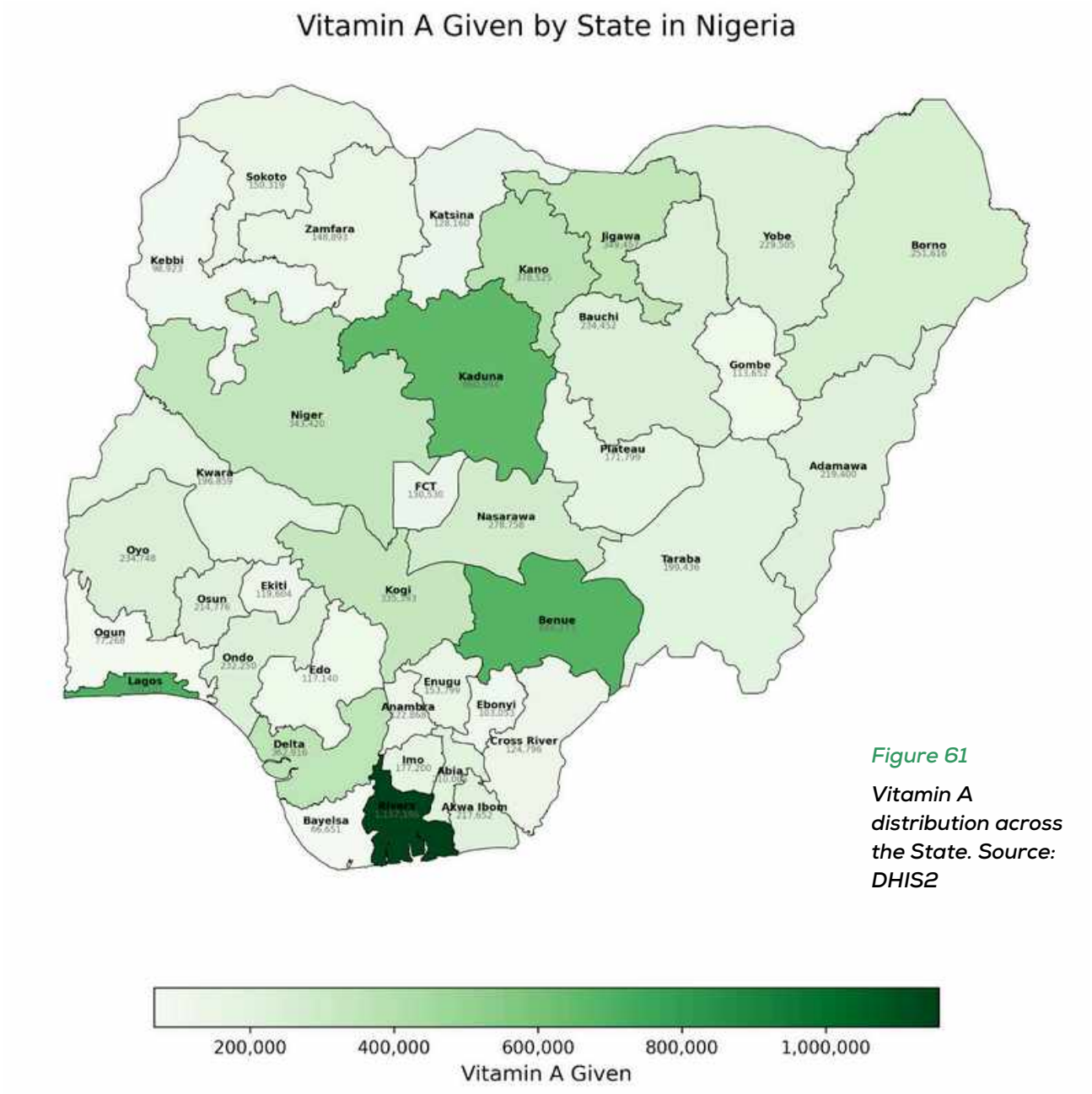


Figure 61

Vitamin A distribution across the State. Source: DHIS2

National RMNCH Scorecard

The National Scorecard highlights disparities in maternal, newborn and child health performance across the states and also includes indicators for non-communicable diseases. It is produced quarterly from routine health facility reports on DHIS2. Future cycles of this scorecard will be adjusted to reduce the influence of outliers, inconsistencies and over or under reporting. Each indicator has at least one state doing well (green) and at least one state that is not on track (red) showing areas that need attention for improvement at the state level.

Table 2: RMNCH Scorecard showcasing State performance (adjusted data from FASTR)

National Scorecare 2025 Quarter Three
Nigeria

Survey comparison

ANC4	SBA	CPR	Penta 3	Fully Immunized	Vitamin A
52	46	15	53	39	37
NDHS24	NDHS24	NDHS24	NDHS24	NDHS24	NDHS24

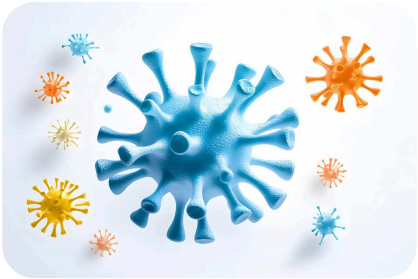
Legend: On track; Progress; Not on track

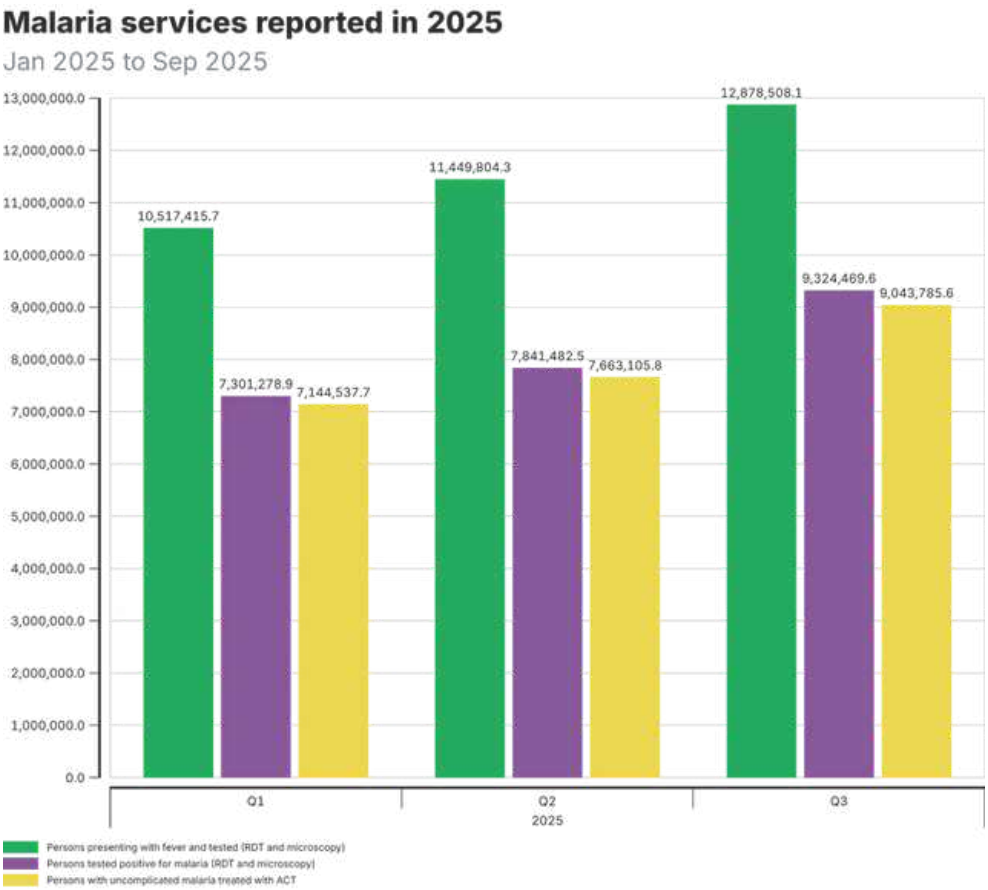
	ANC4/ Expected	Skilled Birth Attendant/ Expected Deliveries	New FP Acceptors/ Women of Reproductive Age	Outpatients/ 100 Person-years	ACT for Uncomplicated Malaria	Penta 3	Fully Immunized	Vitamin A/ 6-59 month children	HTN New per 10,000 person years	Diabetes New per 10,000 person-years	MPCDSR vs Maternal/ Perinatal deaths	NHMIS reports on time with content
Nigeria	37	31	12	38	103	93	82	132	42	11	8	73
Abia	17	13	8	28	101	67	64	140	36	11	0	60
Adamawa	71	113	28	35	99	128	118	112	37	10	2	85
Akwa ibom	8	4	9	13	100	77	87	147	28	6	0	80
Anambra	11	14	4	7	97	84	97	118	25	12	0	66
Bauchi	53	60	12	30	102	81	70	135	39	3	0	87
Bayelsa	8	8	4	13	96	58	47	116	15	4	0	86
Benue	12	31	6	14	99	95	88	111	17	6	0	73
Borno	79	42	11	86	100	143	124	141	91	19	0	75
Cross River	15	24	9	14	99	77	75	100	14	4	0	87
Delta	24	15	4	26	96	81	82	164	31	11	3	72
Ebonyi	22	23	12	31	94	87	81	115	26	6	0	89
Edo	18	13	6	17	103	64	59	71	36	11	0	65
Ekiti	11	8	5	26	99	99	90	127	48	11	51	72
Enugu	13	4	6	17	98	83	50	124	19	7	0	57
FCT	27	17	4	47	297	169	75	258	36	11	45	36
Gombe	49	47	27	44	104	81	70	99	61	6	15	84
Imo	9	5	5	10	94	79	73	141	38	15	34	45
Jigawa	113	102	15	83	99	92	79	91	78	14	7	98
Kaduna	81	66	30	57	98	145	104	121	45	6	24	81
Kano	55	23	26	53	100	83	80	68	56	16	1	80
Katsina	47	22	7	72	99	99	88	90	39	9	6	78
Kebbi	35	48	14	43	100	94	83	99	51	21	0	81
Kogi	21	19	7	18	99	95	95	105	47	8	11	72
Kwara	20	21	9	25	99	108	69	116	32	10	37	75
Lagos	16	15	10	46	92	84	70	261	62	25	0	70
Nasarawa	87	60	19	60	99	122	107	260	50	11	13	86
Niger	42	68	16	47	99	108	92	126	34	8	11	53
Ogun	13	10	4	15	94	74	75	98	22	6	1	66
Ondo	15	11	5	46	101	86	89	107	21	5	30	72
Osun	15	7	6	22	97	82	57	161	37	6	64	70
Oyo	17	17	5	25	98	59	79	256	33	8	0	75
Plateau	26	12	7	22	98	85	58	121	18	7	0	69
Rivers	11	6	5	18	98	99	95	153	43	9	4	62
Sokoto	38	25	20	61	157	87	47	109	36	10	0	96
Taraba	37	43	18	36	103	110	87	132	34	7	0	63
Yobe	96	91	27	69	97	141	125	124	110	17	13	94
Zamfara	35	18	6	30	98	88	79	84	25	4	42	83

Communicable Diseases

Malaria

Indicator	Value / Status
Proportion of pregnant women receiving 3 doses of SP-IPT	51.3% (DHIS2)
Proportion of children under 2 years that received complete (4) doses of malaria vaccine	11% (NPHCDA)
Proportion of all persons (U5 and above 5) that tested positive for malaria with a parasitological test (RDT and/or microscopy)	70.3% (DHIS2)
Percentage of eligible children under 2 years receiving at least 3 doses of malaria vaccine	48% (NPHCDA)
Number of Long-Lasting Insecticidal Nets (LLINs) distributed to targeted risk groups (children under 5 and pregnant women)	3,163,772 (DHIS2)
Number of suspected malaria cases that received a parasitological test in public facilities	35,958,729 (DHIS2)
Number of confirmed malaria cases that received first-line antimalarial treatment	24,544,878 (DHIS2)
Number of pregnant women attending ANC who received 3+ doses of IPTp	3,364,257
Number of children aged 3–59 months who received a full course of SMC	11,711,462 (2024 SMC Campaign Data)





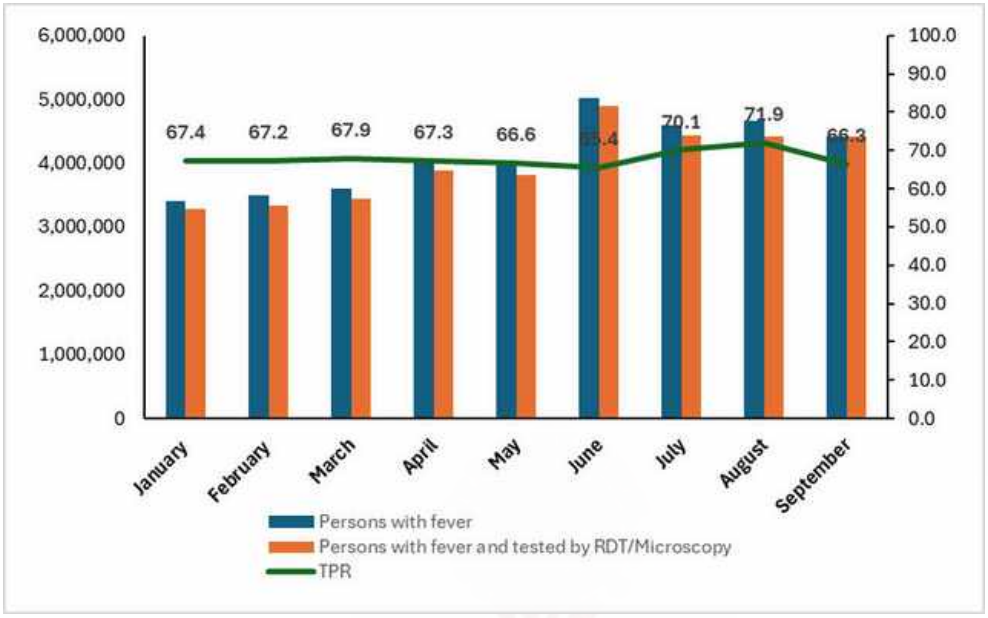


Figure 62

Malaria testing and Positive rate in 2025. Source: DHIS2

Figure 59 & 60 shows both the malaria testing volumes and positivity rate. In 2025, about 68.5 - 72.4% of reported persons presenting with fever tested positive for malaria (via RDT and/or microscopy). The reported number of persons treated for malaria with ACT is 97 - 98% of reported positive tests per quarter. Malaria Test Positivity Rate for the reporting period was between 65 - 71% with the highest Test Positivity Rate recorded in August.

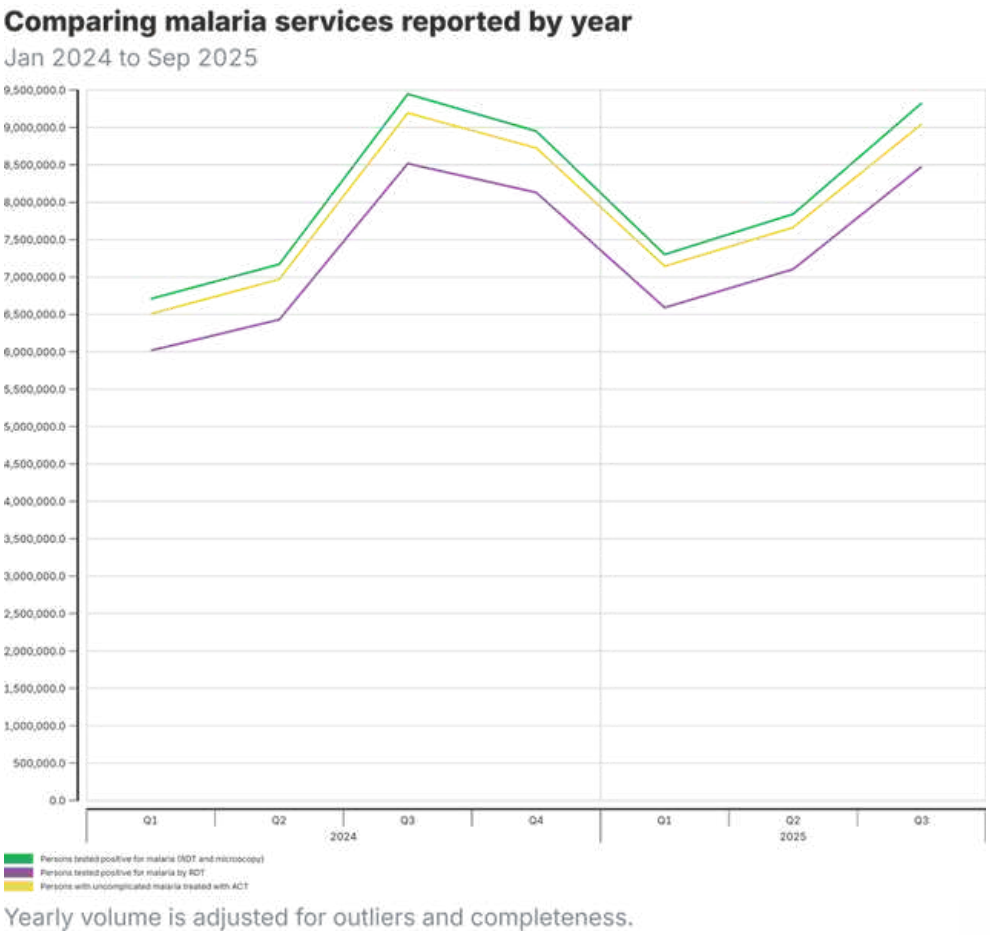


Figure 63

Malaria Services Reported, Nigeria January 2024– September 2025

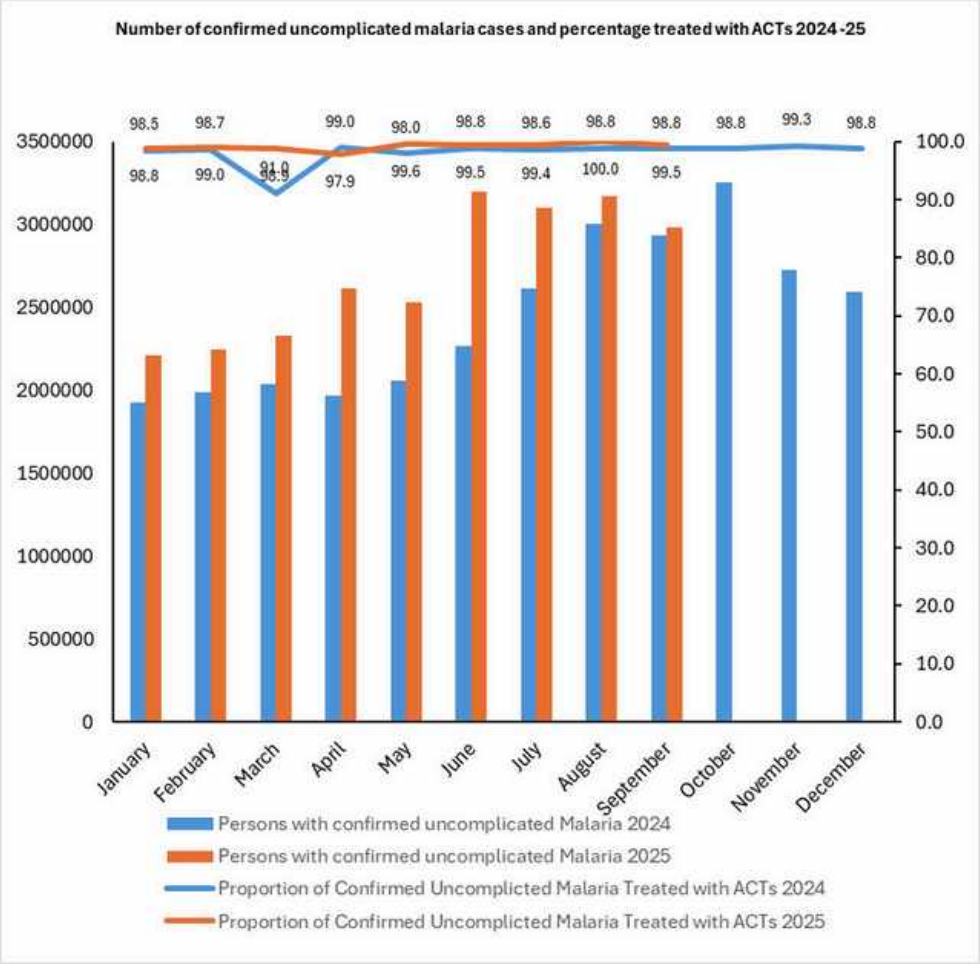
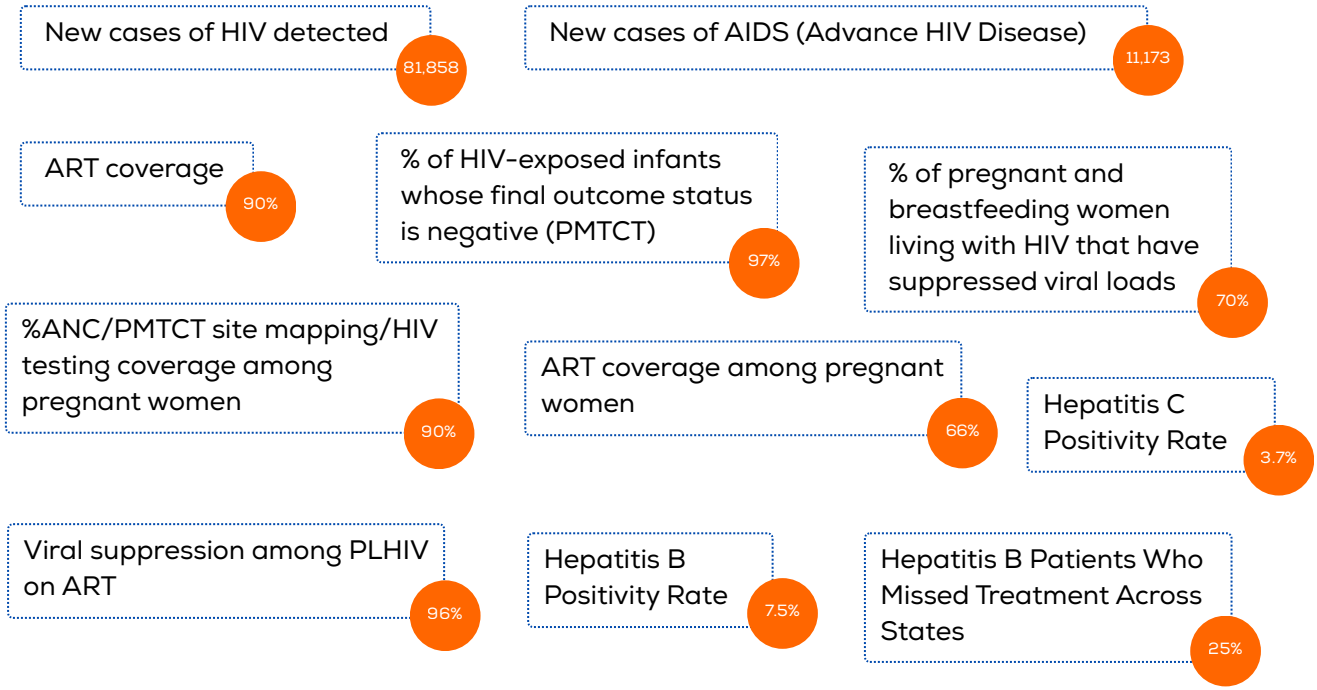


Figure 64

Number of confirmed uncomplicated malaria cases and percentage treated with ACT

The figures (61 & 62) show that between January 2024 and September 2025, malaria service delivery followed a cyclical pattern. All three indicators increased from Q1 to Q2 2024, reaching their highest levels in Q2, before declining through Q4 2024 and Q1 2025. Services rose again in Q2 and Q3 2025. As shown in Figure 62, the target of 98% for proportion of persons with confirmed uncomplicated malaria treated with ACTs was all met across all the month.

HIV/AIDS



In 2025, 9,066 persons were reported to be reactive to Hepatitis B virus (Source; NDARS). In general populations, about 15–20% of HBsAg-positive adults qualify for treatment, this translates to about 906 (lower threshold) that needed treatment. Only 179 (25%) were reported to be on HBV treatment.

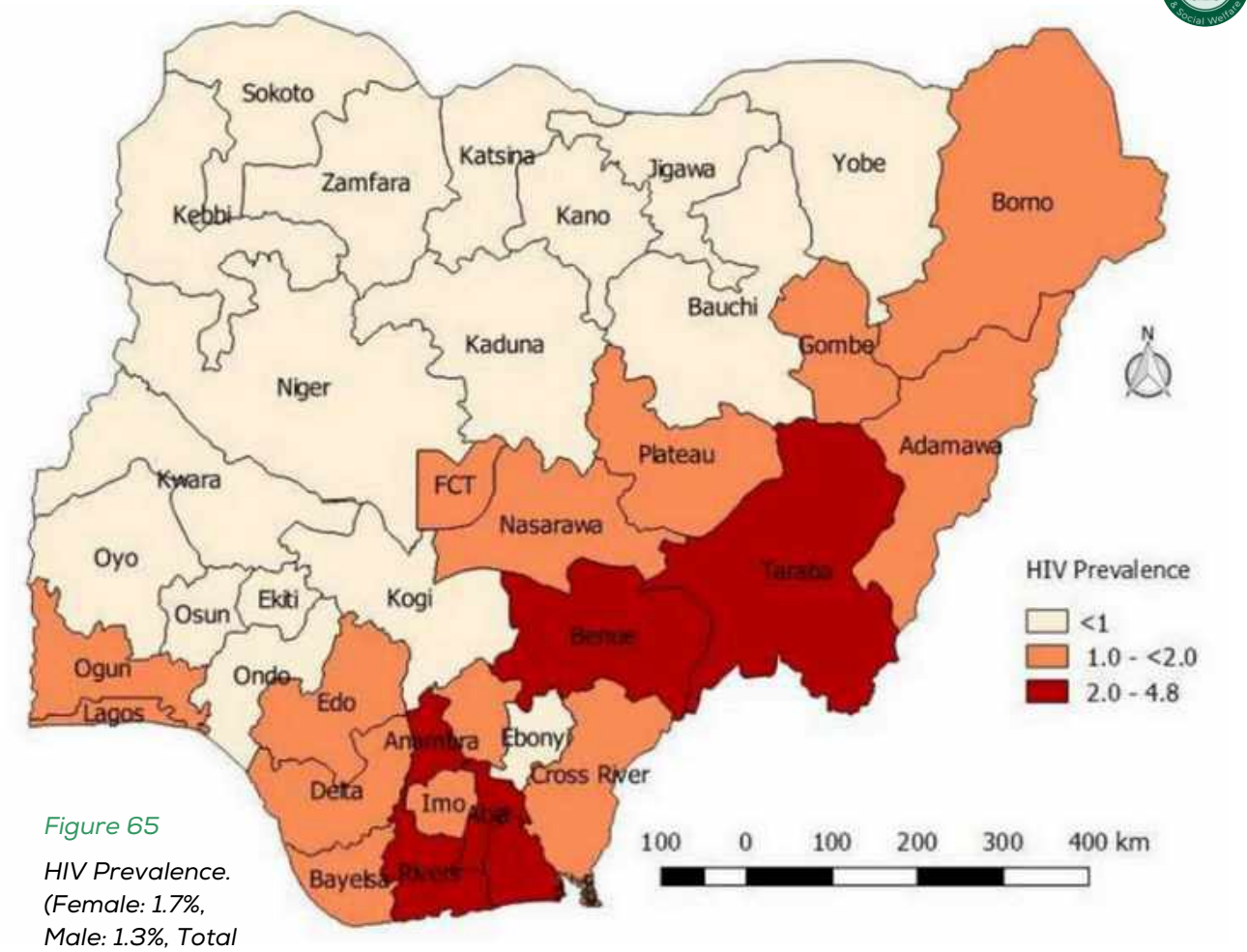
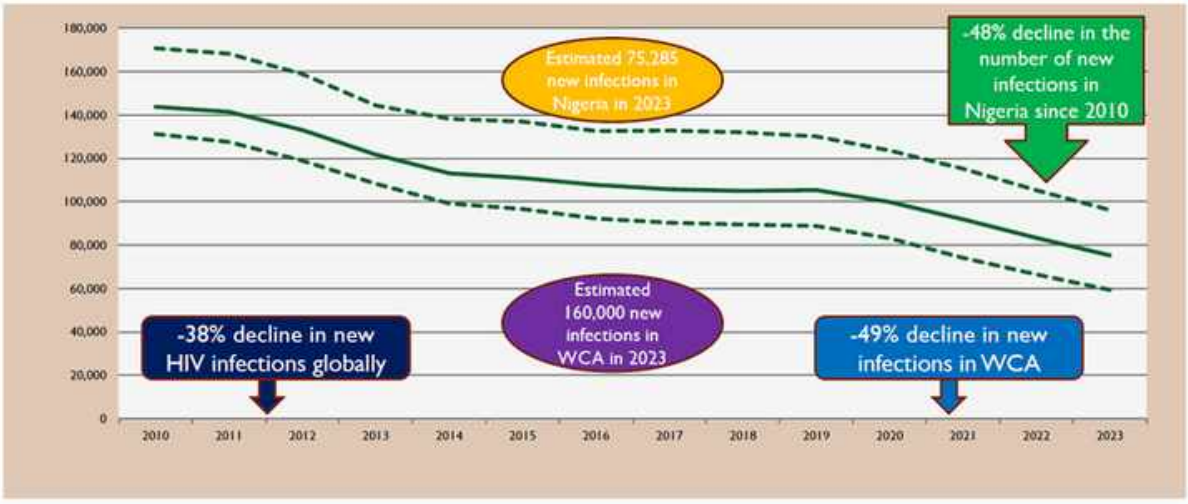


Figure 65

HIV Prevalence. (Female: 1.7%, Male: 1.3%, Total population: 1.3%). Source: NAIIS 2018

Figure 66

Estimated Trend on number of new HIV infections. Source: NASCP 2025



The chart shows a steady decline in new HIV infections globally, in West and Central Africa (WCA), and in Nigeria since 2010, with Nigeria recording a 48% reduction by 2023 and only 64,942 new cases reported in 2025.

Table 3: Hepatitis B and C positivity and treatment adherence across States

SN	State	#persons screened for HBV infection	#persons screened for HBV infection - Reactive	# persons newly started on HBV treatment	HBV Positivity	#persons screened for HCV (HCVAb)	#persons screened for HCV (HCVAb) - Reactive	# persons newly started on HCV treatment	HCV Positivity
1	Adamawa	2,633	298		11.3%	1,941	74		3.8%
2	Delta	1,049	14	2	1.3%	781	2		0.3%
3	Jigawa	380	24		6.3%	321	22		6.9%
4	Kano	28,461	2,231	17	7.8%	12,730	66		0.5%
5	Katsina	149	28		18.8%	44			0.0%
6	Kebbi	193	8		4.1%	0			
7	Kwara	3,627	54		1.5%	12			0.0%
8	Lagos	41,982	2,042	31	4.9%	27,962	460		1.6%
9	Nasarawa	38,035	3,348	104	8.8%	37,227	2,097		5.6%
10	Niger	3,486	668		19.2%	2,523	242		9.6%
11	Taraba	223	41		18.4%	223	29		13.0%
12	Zamfara	9,384	310		3.3%	104	2		1.9%

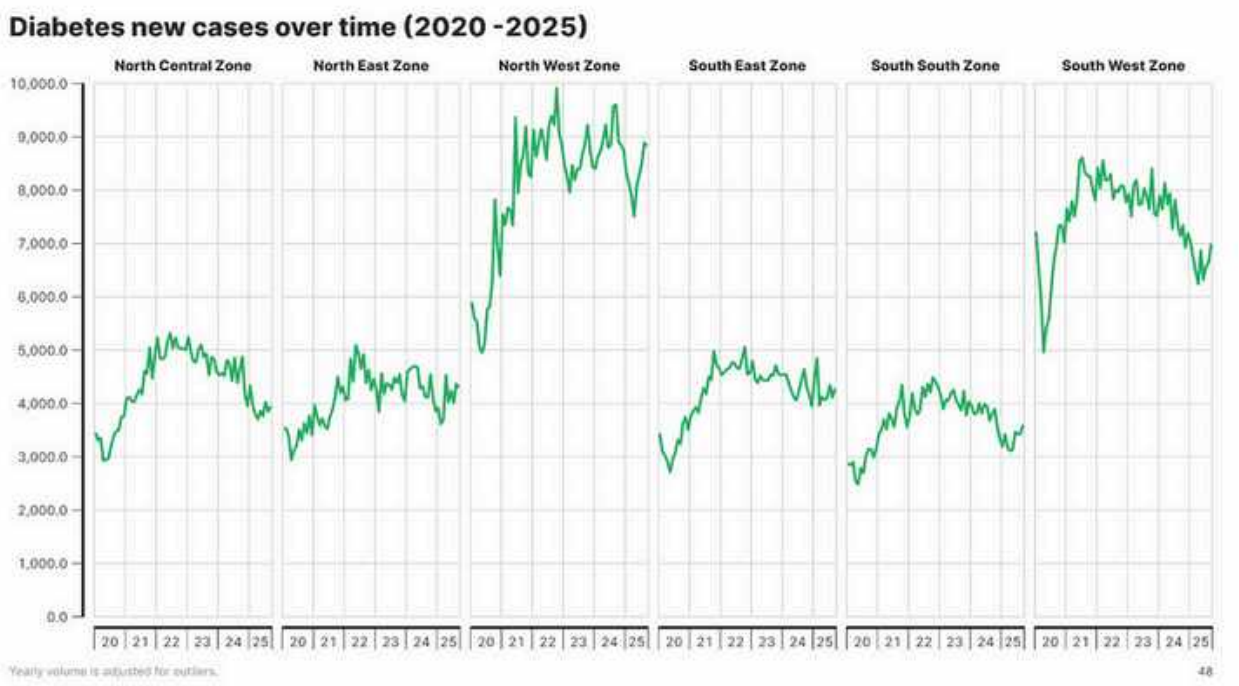
Table 2 shows that only 12 out 36 states+FCT reported on Viral Hepatitis testing and treatment in 2025 (source: NDARS). Niger, Katsina and Taraba reported HBV positivity rates of above 18%.

Tuberculosis, Leprosy & Buruli

TB incidence (new cases)	219 per 100,000 (2024 Global TB Report)
TB treatment coverage	79% (2024 Global TB Report)
Number of TB cases notified	332,466
TB treatment success rate	92%
TB patients who know HIV status	324,320 (98%)
ART coverage for TB/HIV co-infection	92%
TPT coverage – child contacts (under 5 years)	70,452
Number of people in contact with TB patients who began preventive therapy	356,371
% of DRTB patients successfully treated among DRTB patients notified	81%
Number of LGAs with functional WHO-recommended Molecular Rapid Diagnostic (WRD) platforms	651 (84%)
Number of Leprosy cases notified	1,412
Number of Buruli ulcer cases notified	302
Proportion of Leprosy Grade 2 disability cases reported	6%

Non-Communicable Diseases

% of States with a functional NCD coordination mechanism	72%
New cases of hypertension	995,318
New cases of diabetes	274,587
Proportion of diagnosed cancer patients accessing the Cancer Fund	6,200 applied; 1,800 fully profiled
Number of cancer disease burden cases	269,109 (2018–2022)
Number of fully functioning cancer care facilities	13 (9 government, 4 private)
% of health facilities offering NCDs and Mental Health Services	20%
% of Neuropsychiatric hospitals with a functional Mental Health Assessment Committee	0%



This chart illustrates the distribution of newly diagnosed diabetes cases across Nigeria's six geopolitical zones between 2020 and 2025. The North-West Zone consistently records the highest number of new cases, followed by the South-West Zone, while the South-East and South-South Zones show comparatively lower figures. Overall, most zones display a rising trend in diagnoses over the years, with a slight decline observed in 2025.

Figure 67

Trends of New Diabetes cases among Nigeria's Geopolitical Zones (2020 – 2025). Source: DHIS-2)

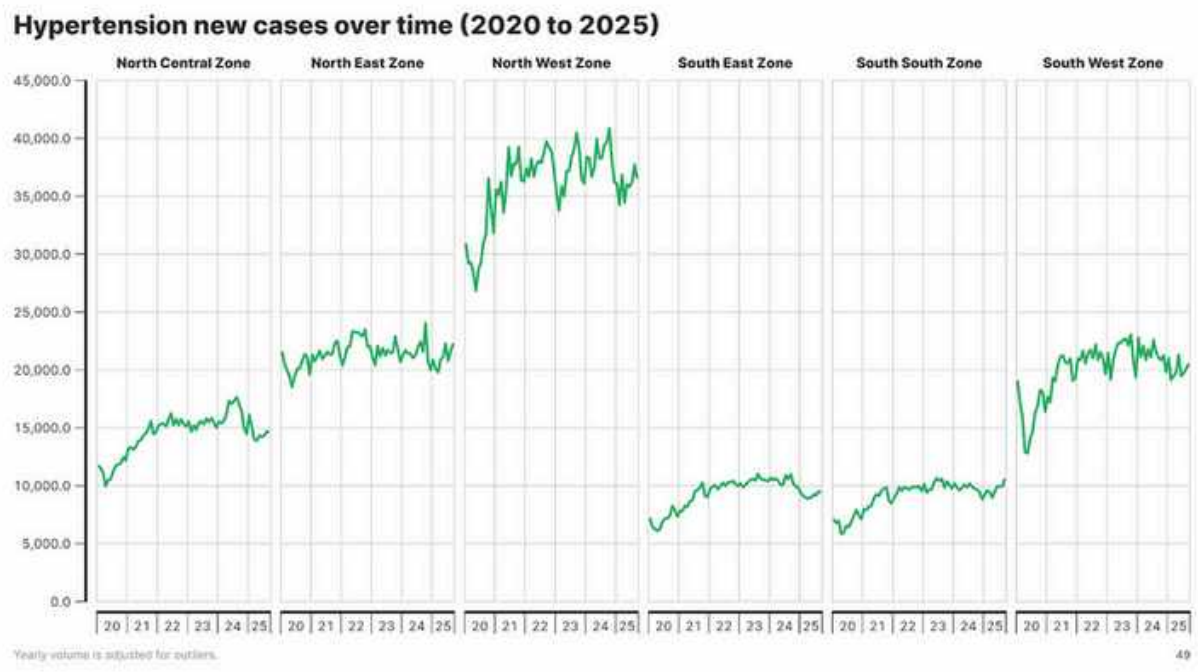


Figure 68

Trend of new cases of hypertension, quarters in 2025. Source: DHIS-2

The figure above illustrates the distribution of newly diagnosed hypertension cases across Nigeria's six geopolitical zones between 2020 and 2025. The North-West Zone consistently records the highest number of new cases, rising from about 367,000 in 2020 to nearly 459,000 in 2025, while the South-East and South-South Zones show comparatively lower figures. Most zones display a steady upward trend over the years, highlighting the growing burden of hypertension nationwide.

Neglected Tropical Diseases

Indicator	Value
% of hydrocele cases operated	79%
% of Lymphodema cases cared for	75%
% of LGAs that are no longer in need of Lymphatic filariasis treatment	65%
% of LGAs that are no longer in need of Trachoma treatment	84%
% of States that are no longer in need of Onchocerciasis treatment	34%
% of States that are no longer in need of Schistosomiasis treatment	0%
% of States that are no longer in need of Soil Transmitted Helminthes treatment	0%

Leading causes of Deaths

Both report from the States(self-reports) and the VASA 2019 data show similar patterns in the causes of death among neonates and children U-5 mainly birth asphyxia, prematurity, infections, malaria, diarrhoea, and malnutrition. The key difference is that VASA 2019 captures a broader range of causes. Maternal complications and cardiovascular diseases are reported to be the leading causes of adult deaths in health facilities, followed by malaria, cancer, and HIV/AIDS.

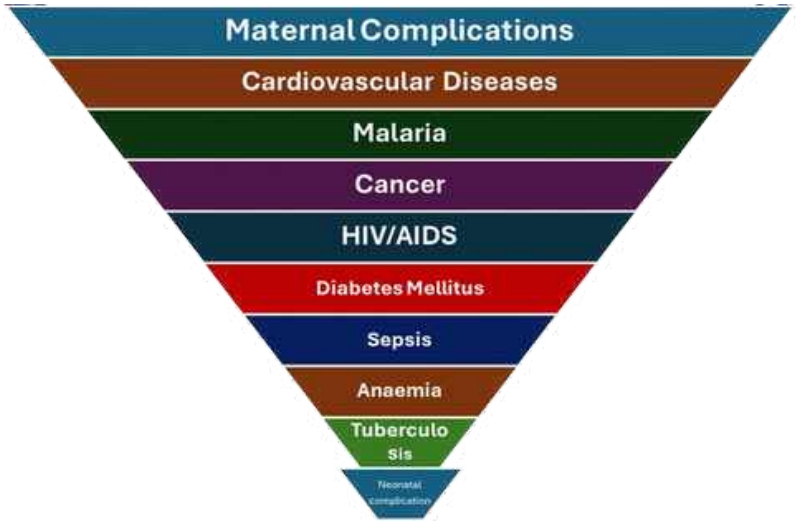
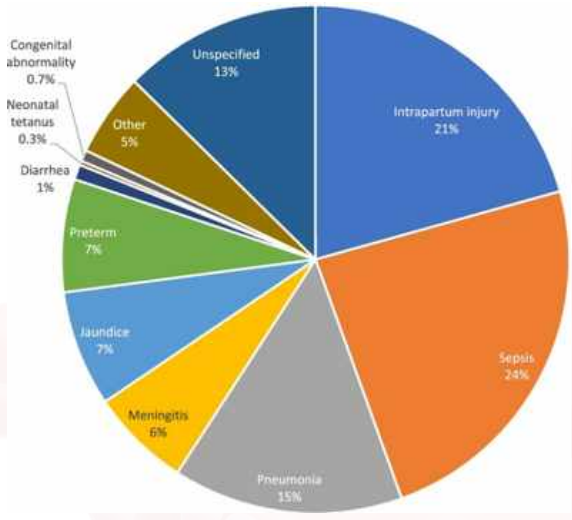


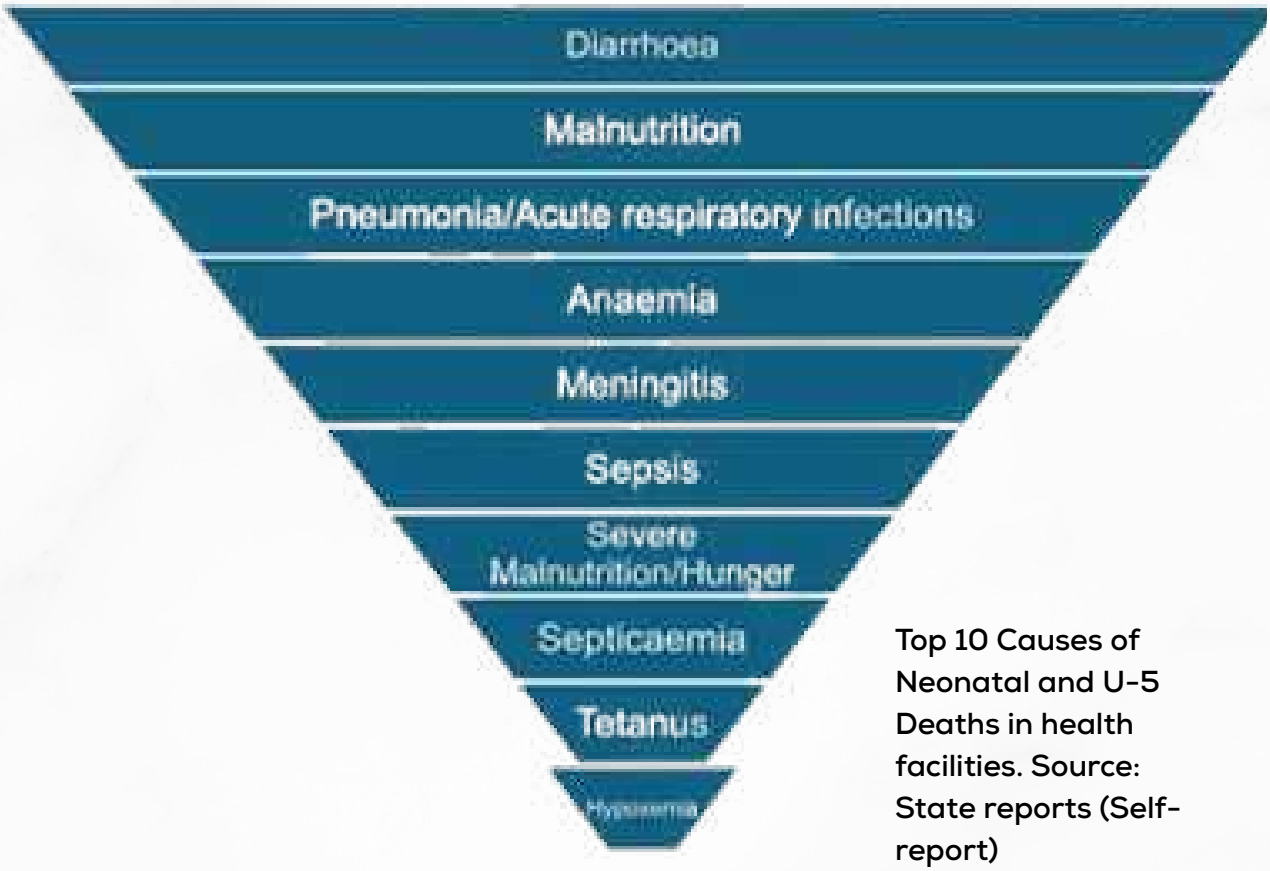
Figure 69

Top 10 leading causes of deaths in facility (All population). Source: State reports (Self-report)

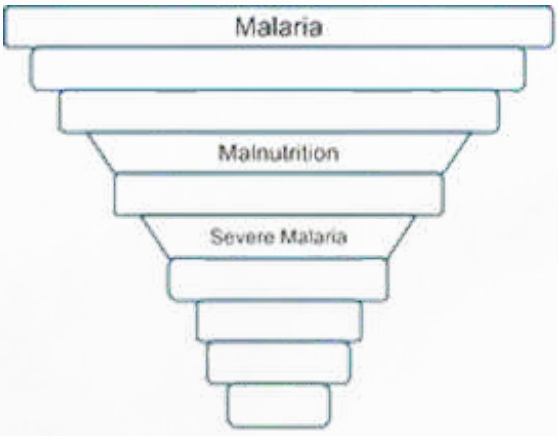
Top 10 Causes of Neonatal Deaths in health facilities (0-28 days). **Source: State reports (Self-report)**



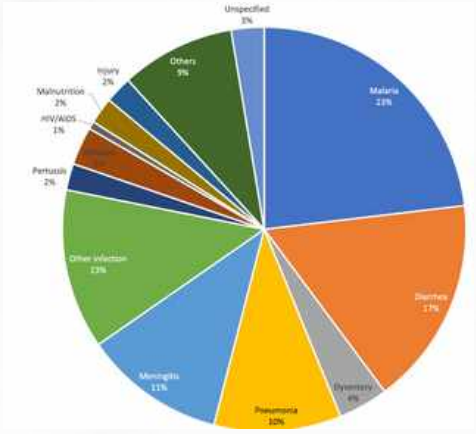
Causes of Neonatal Deaths **(Source: VASA 2019)**



Top 10 Causes of Neonatal and U-5 Deaths in health facilities. Source: State reports (Self-report)



Top 10 Causes of Under-5 (1-59 months) Deaths in health facilities. Source: State reports (Self-report)



Causes of Deaths in Under-5 (1-59months). Source: VASA 2019)

Figure 70: Top 10 leading causes of deaths in children compared with VASA 2019

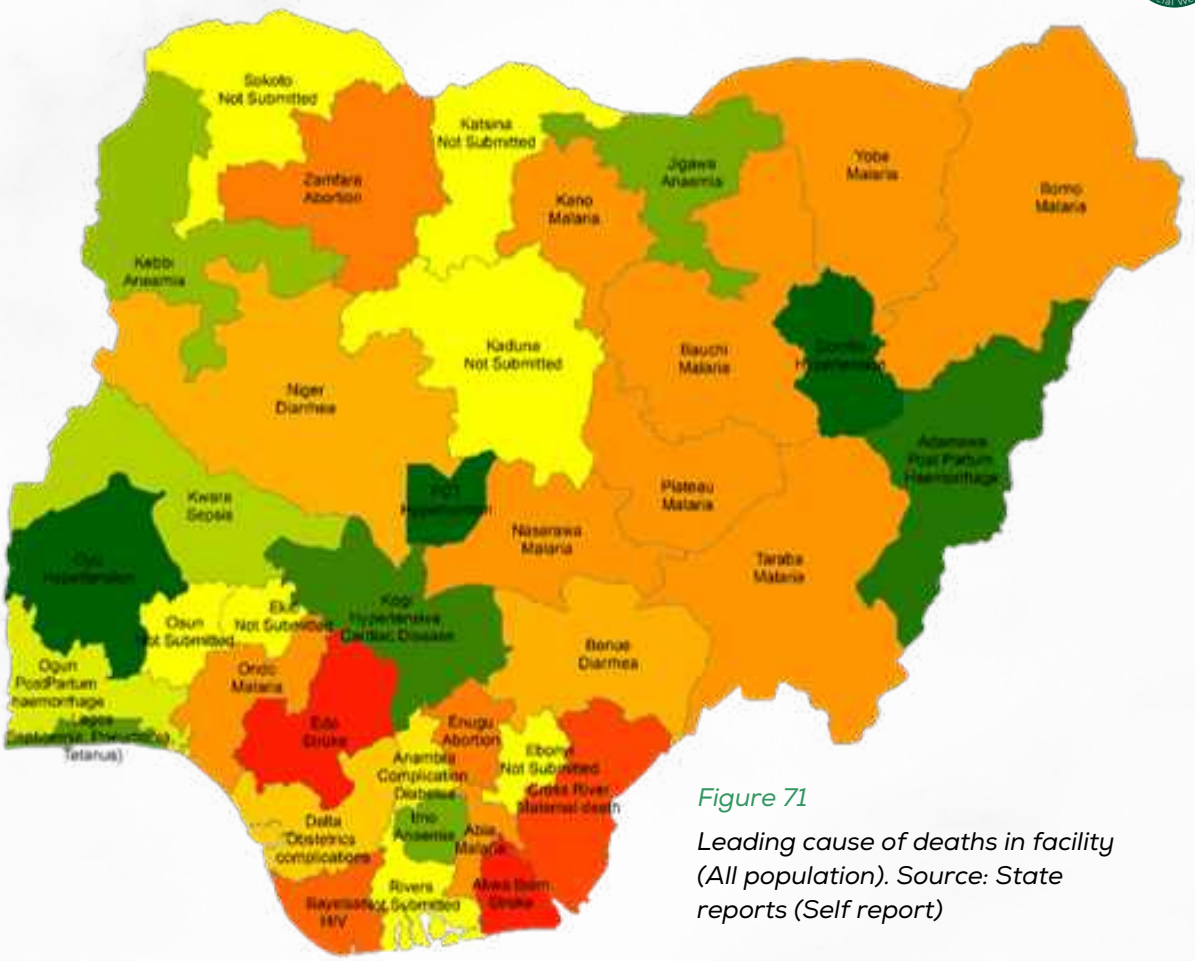


Figure 71

Leading cause of deaths in facility (All population). Source: State reports (Self report)

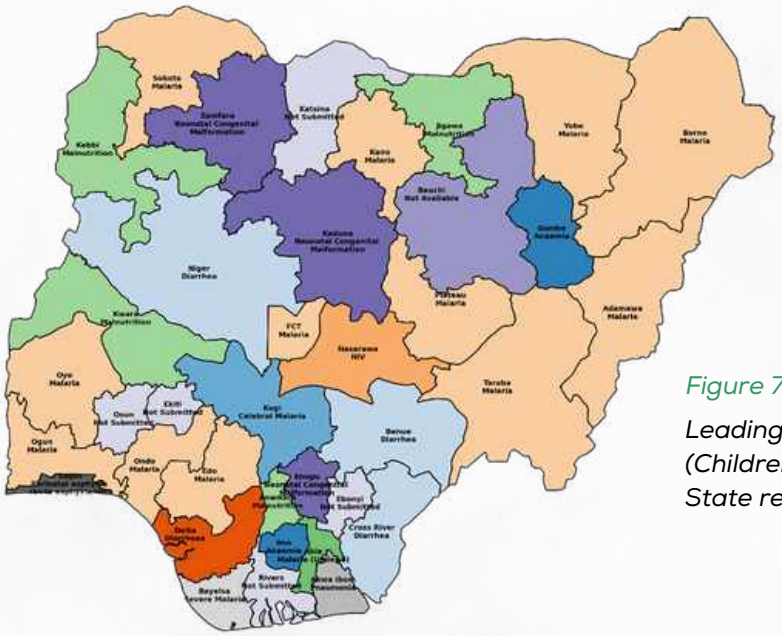


Figure 72

Leading cause of deaths in facility (Children Population). Source: State reports (Self report)

Summary of State-Level Performance Indicators

Reports from the states show significant health system gaps across the country. Over 5,000 new cases of cancer were diagnosed, but none (0%) of these patients accessed the cancer fund. On average, 50% of facilities had no stockout of heat-stable Carbetocin, and 50% of women of reproductive age were using modern contraception. Additionally, 53% of women and 56% of newborns received postnatal care within 48 hours.

S/N	State	% of facilities with no stockout of heat stable Carbetocin	Proportion of women of reproductive age who are currently using a modern method of contraception	% of women receiving postnatal care check-ups within 48hrs of delivery	% of newborns receiving postnatal care check-ups within 48hrs of delivery	New cases of Cancer diagnosed	Proportion diagnosed cancer patients accessing the Cancer fund	Number of CHEWs trained on Integrated Health care services
1	Abia		63	49%	90%		0	
2	Adamawa	0%	93	66%	66%		0	140
3	Akwa Ibom	0%	10	24%	24%	41	0	1,223
4	Anambra		4	58%	53%	133	0	623
5	Bauchi		16	39%			0	
6	Bayelsa	0%	6	16%	16%	0	0	840
7	Benue	0%	82	11%	10%		0	595
8	Borno	43%	72	94%	94%	123	0	100
9	Cross River		73	50%	50%	63	0	2,668
10	Delta	0%	13			398	0	272
11	Ebonyi		37	85%	87%	63	0	
12	Edo	NA	80	56%	NA	34	0	785

13	Ekiti	0%	74	41%	44%		0	
14	Enugu		68	6%	7%	55	0	604
15	FCT		81	79%	79%		0	200
16	Gombe	100%	41	56%	78%	41	0	
17	Imo	22%	104	92%	93%		0	263
18	Jigawa	NA	324128??		88%	423	0	950
19	Kaduna	77%	950228??	0%	0%	0	0	555
20	Kano		33	1%	1%	579	0	4,565
21	Katsina		58	42%	40%	118	0	0
22	Kebbi	15%	13	116%	116%	119	0	450
23	Kogi		67	17%	17%		0	993
24	Kwara		12	7947	61%	50	0	
25	Lagos	100%	14	49%	40%	1243	0	
26	Nasarawa	NA	213746??	77%		26	0	1,621
27	Niger	100%					0	
28	Ogun	0%	79	78%	78%	220	0	0
29	Ondo	64%	101	73%	73%	87	0	-
30	Osun	0%	73				0	100
31	Oyo	100%	11	14990??	15308??		0	
32	Plateau	95%	15	42%	42%	550	0	
33	Rivers (Reported only Q1 & Q2)		63924??	4876	4794??	321	0	
34	Sokoto							

35	Taraba	0%	80	79%	79%		0	602
36	Yobe		57	75%	75%	182	0	3,785
37	Zamfara	80%	8	59%	59%	206	0	

NA: Data Not Available

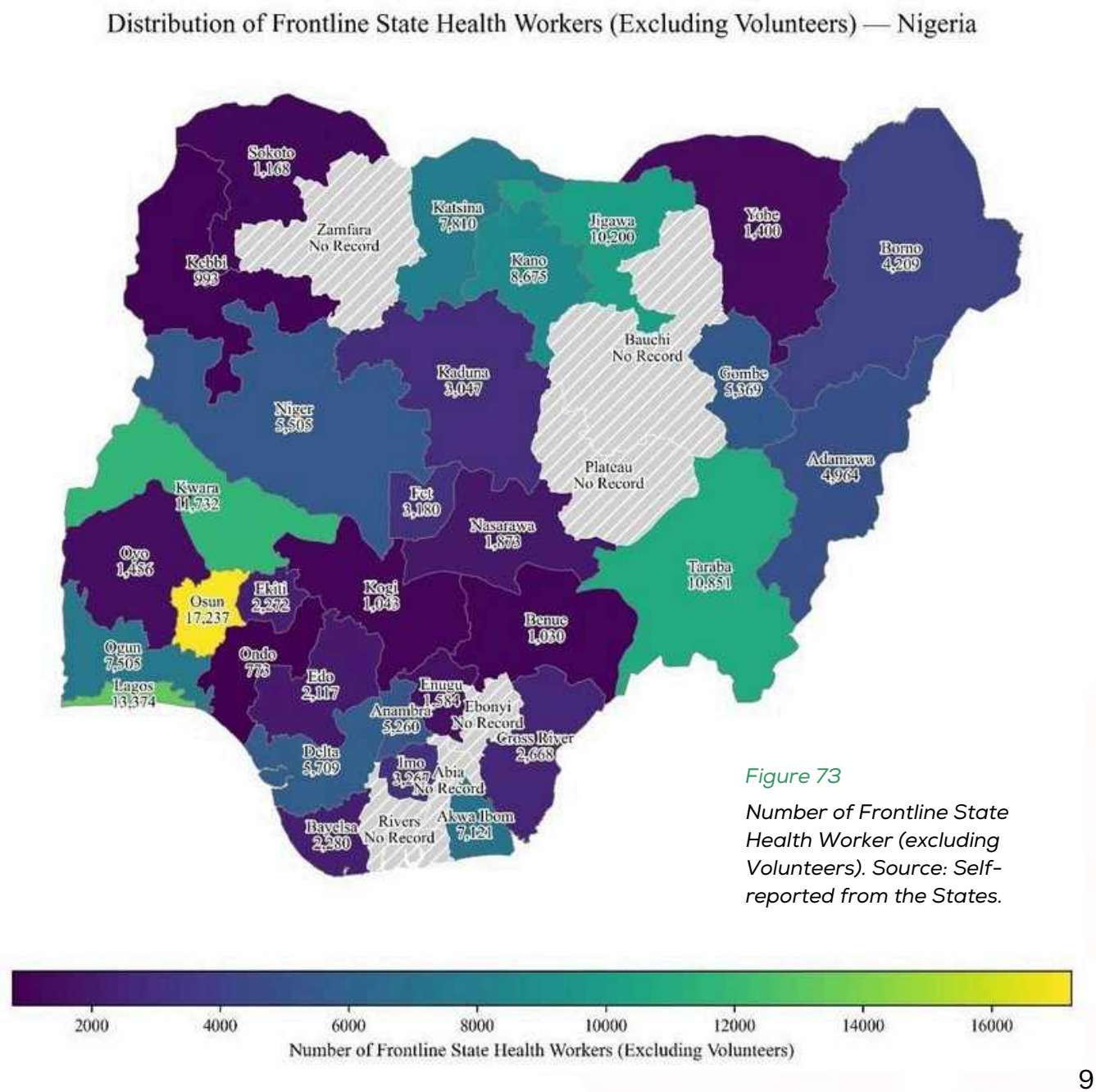


Figure 73

Number of Frontline State Health Worker (excluding Volunteers). Source: Self-reported from the States.

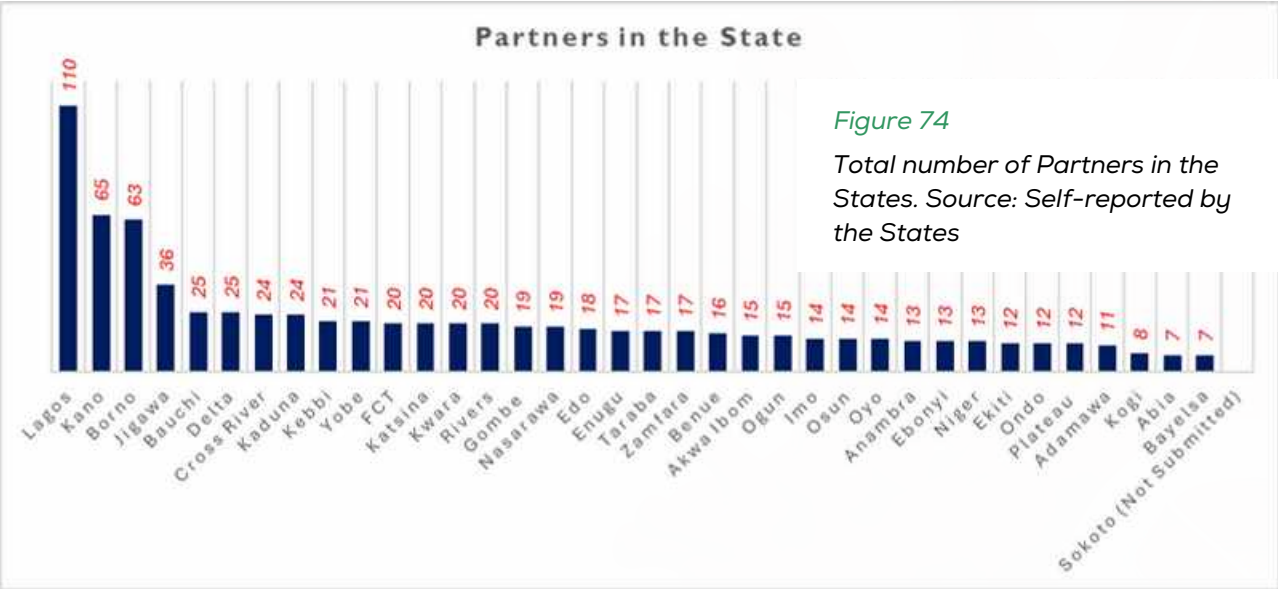


Figure 74

Total number of Partners in the States. Source: Self-reported by the States

Figure 74 Total number of Partners in the States. Source: Self-reported by the States

Emergency medical services (NEMSAS, SEMSAS)

Ambulance Services

Indicator	Value
Total number of ambulances (Public)	502
Total number of ambulances (Private)	21
of states with operational EMT	81%
Percentage of FTHs with operational EMT	15.5% (NEMSAS)
Percentage of validated BHCPF PHCs that meet PHC standards	21%
Level 2	

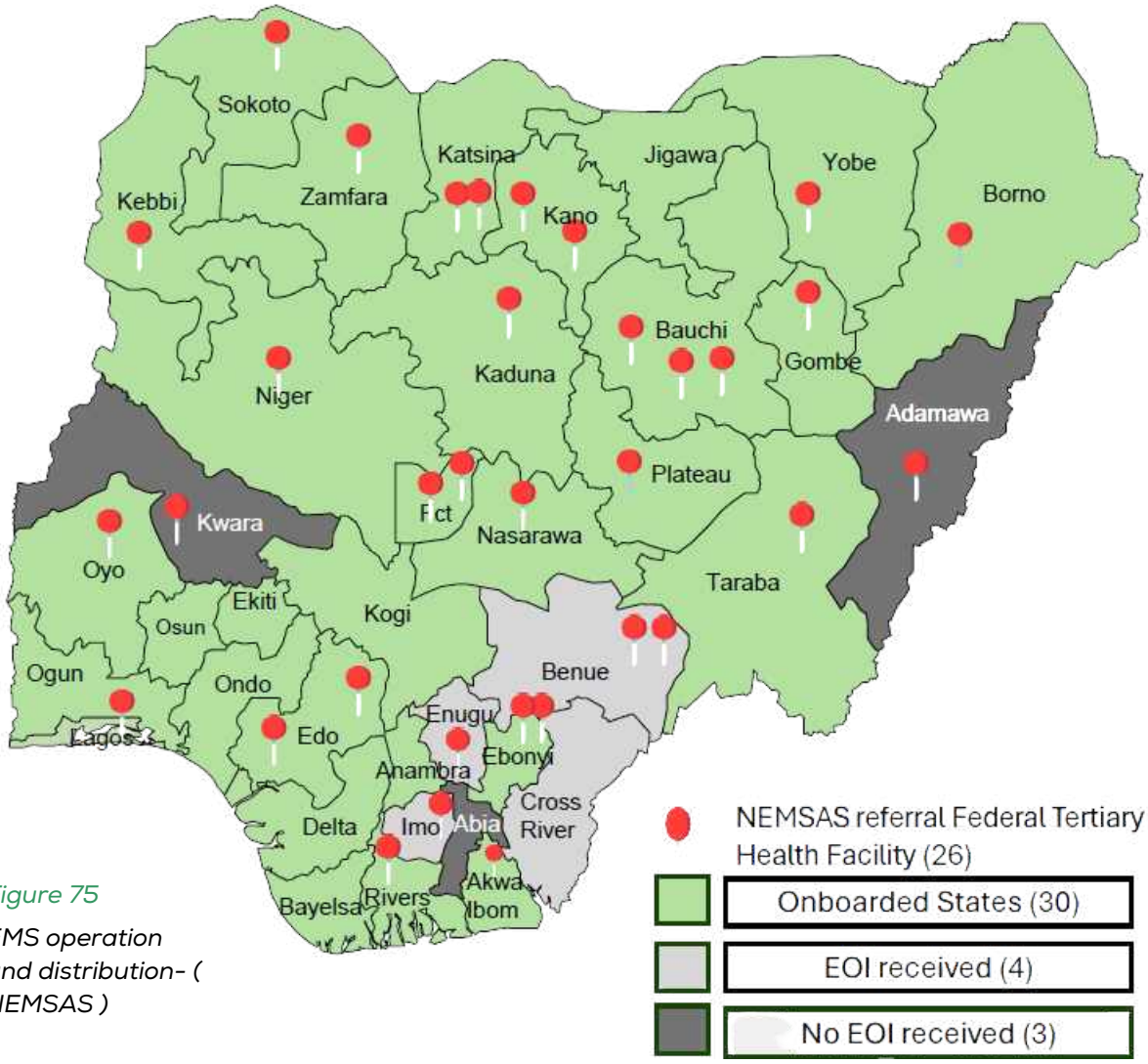


Figure 75

EMS operation and distribution- (NEMSAS)

Tertiary Healthcare Performance

Indicator	Value / Status
Total attendance at FTHs	2,764,089
Outpatient visits	1,211,829
Follow-up outpatient visits	1,769,980
Total admissions	226,943
Average length of stay / hospitalization	7 days
Bed occupancy rate	59%
Discharges	183,862
In-patient deaths	14,857
Number of major surgeries performed	30,516
Number of minor surgeries performed	12,494
Total number of PPH cases	16,964
Total laboratory investigations	1,923,626
New Federal Tertiary Hospitals established in 2025	-4 (Hospital Services)
Federal Tertiary Hospitals with certificate of standards	2,520
Number of tertiary facility health workers who received training on specialized care quarterly to improve access and quality of specialized care	5
Proportion of FTHs that had annual supportive supervisory visits	0
Percentage of FTHs issued with certificates of standards (provisional)	23%

The table above summarizes key performance indicators from the Federal Tertiary Health Facilities, indicating high outpatient and follow-up visit volumes with a moderate bed occupancy rate (59%), although few facilities reported over 30days. The report shows a substantial inpatient mortality count within the year (14,857). Key questions: What factors drive the long hospital stay and the relatively high inpatient deaths. Can possible strategies be deployed to address them?

Report Summary from Tertiary Health Facilities

The Q3 report on tertiary health facilities provides useful insights into service delivery trends across Federal tertiary hospitals. Jos University Teaching Hospital and University of Benin Teaching Hospital recorded the highest patient volumes and diagnostic activities. However, several data quality and reporting gaps were observed. Some facilities, such as the Federal Teaching Hospital Azare, reported figures that appear inconsistent (e.g., outpatient visits exceeding total attendance), indicating possible data entry or aggregation errors. Approximately five health facilities reported an average length of stay exceeding 30 days, while four reported a 100% bed occupancy rate.

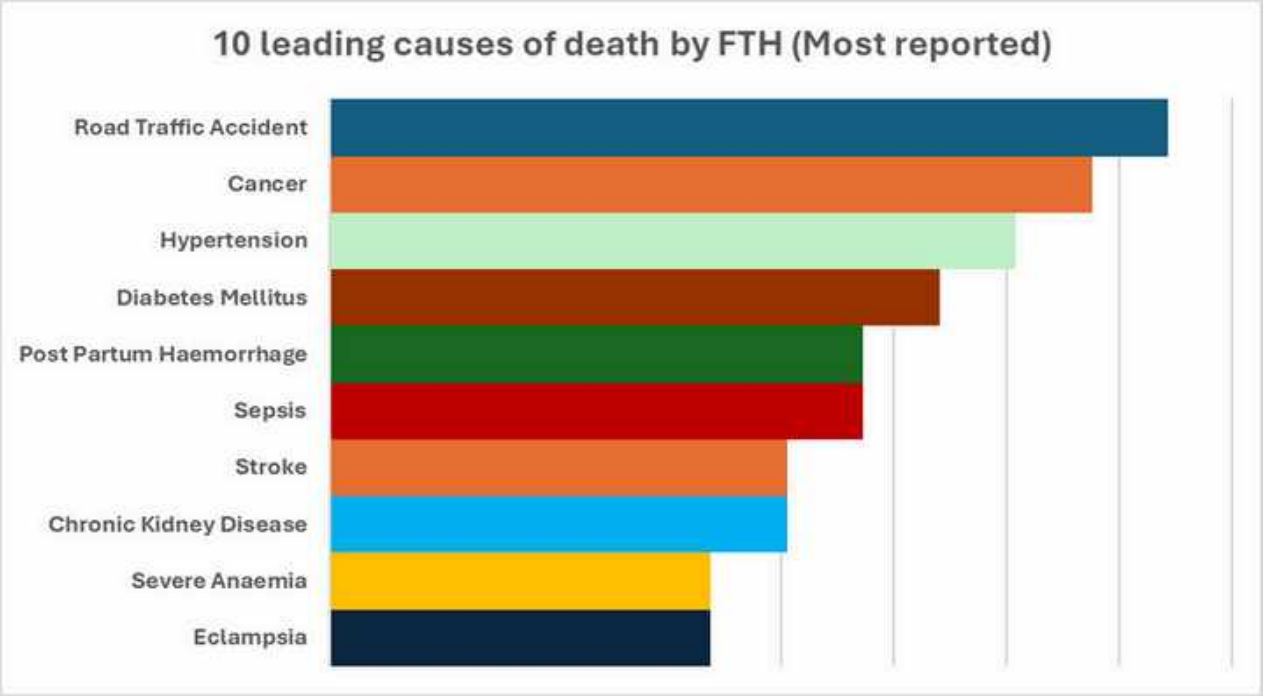
REPORT SUMMARY FROM TERTIARY HEALTH FACILITIES AS AT Q3

Tertiary Health Facility	Total facility attendance	New outpatient visits	Follow-up outpatient visits	Total Admissions	Average length of stay (days)	Bed occupancy rate (%)	Discharges	In-patient death	Number of major surgeries performed	Number of minor surgeries performed	Total number of PPH cases	Total X-ray Ultrasound performed	ECG procedures	All Laboratory Investigations	Number of patients counsel with headings
Federal Medical Center Bida	79,586	29,163	50,423	10,211	5	100%	9,122	761	1,002	458	26	9,880	1,139	10,246	86
Federal Medical Center Jabi, Abuja	155,214	40,771	103,750	7,208	7	90%-97%	5,937	453	2,661	1,907	13	8,876	3,822	179,772	495
Federal Medical Center Keffi	65,000	55,000	2,500	3,500	5	100%	1,200	-	80	130		1,450	1,600	35,000	60
Federal Medical Center Misau	10,996	5,621	2,882	1,643	8	17%	1,021	41	300	28	50	2,176	-	10,482	5
Federal Medical Center Owo	52,650	15,135	32,414	3,133	9	0	2,792	290	737	449	45	7,080	1,117	36,731	-
Federal Medical Center Wase Plateau	6,077	3,831	2,649	1,055	4	83%	857	52	60	22	3	32	-	3,264	21
Federal Medical Center Yenagoa	43,847	10,088	33,759	5,409	0	51%	5,093	402	328	200	17	794	-	-	165
Federal Medical Center, Ntl Aba Abeokuta	100,838	30,627	70,211	4,547	6	56%	4,011	413	1,194	314	26	5,999	2,274	66,198	-
Federal Medical Center Dauta	60,478	37,741	17,776	4,961	6	63%	2,715	191	324	315	60	2,769	414	38,437	113
Federal Medical Center Birnin Kudu	147,383	33,334	163,582	16,666	6	58%	14,633	493	582	367	594	8,488	2,194	74,887	49
Federal Medical Center Bayelsa	43,847	10,088	33,759	5,409	12	51%	5,093	402	328	200	17	794	-	19,391	165
Federal Medical Center Epe (Reported Only Q3)	55,068	8,892	17,049	760	3	14%	726	10	315	90	1	2,155	254	8,053	9,003
Federal Teaching Hospital Azare, Bauchi	95,264	315,831	66,364	14,615	4	52%	13,149	1,156	1,589	272	40	14,438	818	64,142	3,223,700
Federal Teaching Hospital Lokoja	72,198	18,783	53,415	4,470	9	81%	3,693	325	1,073	325	13	4,040	1,515	43,535	3
Federal Teaching Hospital Katsina	125,698	26,936	98,762	14,517	6	47%	14,657	856	2,172	773	21	33,871	654	48,884	-
Federal Teaching Hospital Maiduguri	36,170	6,001	28,353	641	90	100%	533	2	-	-	-	5,144	508	7,787	23
Federal University Teaching Hospital Gusau	141,175	44,911	96,264	11,363	5	47%	9,322	973	900	390	30	7,091	151	81,336	23
Federal Teaching Hospital Ido, Ekiti	60,086	15,665	44,421	2,903	8	36%	2,554	152	346	214	8	4,221	703	92,894	24
Modibbo Adama University Teaching Hospital	63,005	21,798	41,207	9,980	36	94%	3,835	840	1,166	722	120	14,899	1,121	49,792	3,978
Federal University Teaching Hospital Lafia	170,682	49,065	121,617	13,527	6	84%	10,808	768	1,376	205	101	12,946	928	17,813	-
University College Hospital Ibadan	126,315	29,118	97,197	13,481	7	36%	9,552	1,192	1,422	400	10	7,542	3,441	230,644	-
University of Benin Teaching Hospital	203,358	74,752	107,647	13,538	8	60%	12,338	1,019	3,302	1,408	33	29,277	3,488	186,932	4,058
University of Uyo Teaching Hospital	92,503	20,329	72,174	9,393	7	51%	8,397	784	932	190	1	4,566	1,004	-	-
Jos University Teaching hospital	244,263	141,408	92,692	10,163	10	53%	8,896	902	1,652	621	21	23,630	3,745	264,718	707
Ahmadu bello teaching hospital, Zaria	82,935	15,916	62,969	7,518	10	37%	6,558	1002	743	169	3,936	9,488	772	42,060	1,336
National Hospital Abuja	137,054	44,662	82,416	9,976	6%	95%	9,114	891	1,648	857	25	19,786	3,180	122,077	200
National Orthopedic Hospital Enugu	15,294	2,492	7,336	1,178	30	84%	1,086	51	853	375	-	5,155	308	38,861	7
National Orthopedic Hospital Jalingo, Taraba State	1,580	842	748	78	3-90days	0	53	-	32	20	-	-	-	-	-
National Orthopaedic Hospital Jos	736	356	380	-	0	0	-	0	-	-	-	301	-	928	-
National Orthopaedic Hospitals, Jos, Plateau State (Q3 Only)	736	356	380	-	0	0	-	0	-	-	-	301	-	928	-
National Orthopaedic Hospital, Yaba, Lagos State	66,083	10,665	55,418	4,461	20	76%	2,009	38	1,014	506	-	18,647	1,023	69,113	198
National Obstetric Fistula Centre Ningi Bauchi, State Nigeria	11,266	3,505	2,246	1,665	17	98%	1,429	73	503	10	8	3,134	-	18,307	3,813
National Obstetrics Fistula Centre, Abakaliki	29,663	23,343		2,873	<21	88%	2,787	86	158	131	16	5,666	-	39,222	109
National Obstetric Fistula Centre Ruga Katsina	13,842	8,222	5,574	2,216	31	91%	1,803	4	331	10	139	1,193	-	-	-
National Obstetric Fistula Centre Benin (Reported Only Q3)	207	5	57	7	18	20%	5	0	5	-	-	-		109	9
Federal Neuro Psychiatric Hospital, Kaduna	31,662	5,474	27,304	970	0				-	-	-	267	31	13,396	-
Specialist Teaching Hospital Irrua	81,586	22,950	58,636	11,989	0	100%	7,375	231	1,090	250	11,588	1,270	-	-	-
National Ear Care Center Kaduna	39,744	24,093	15,649	719	11	62%	709	4	300	166	-	1,222	-	7,687	8

Table 4: Summary of report from 38 FTHs. Source: Self-reported

Table 4:: Summary of report from 38 FTHs. Source: Self-reported

The figure presents the top 10 causes of death as self-reported by Federal Teaching Hospitals (FTHs), ranked by how frequently each was mentioned. Road Traffic Accidents emerged as the most commonly reported cause, followed by Cancer and Hypertension reflecting the perceived burden across FTHs.



10 leading causes of deaths in FTHs. Source: Self-reported

Figure 76 *Map of 10 leading causes of deaths in FTHs. Source: Self-reported*

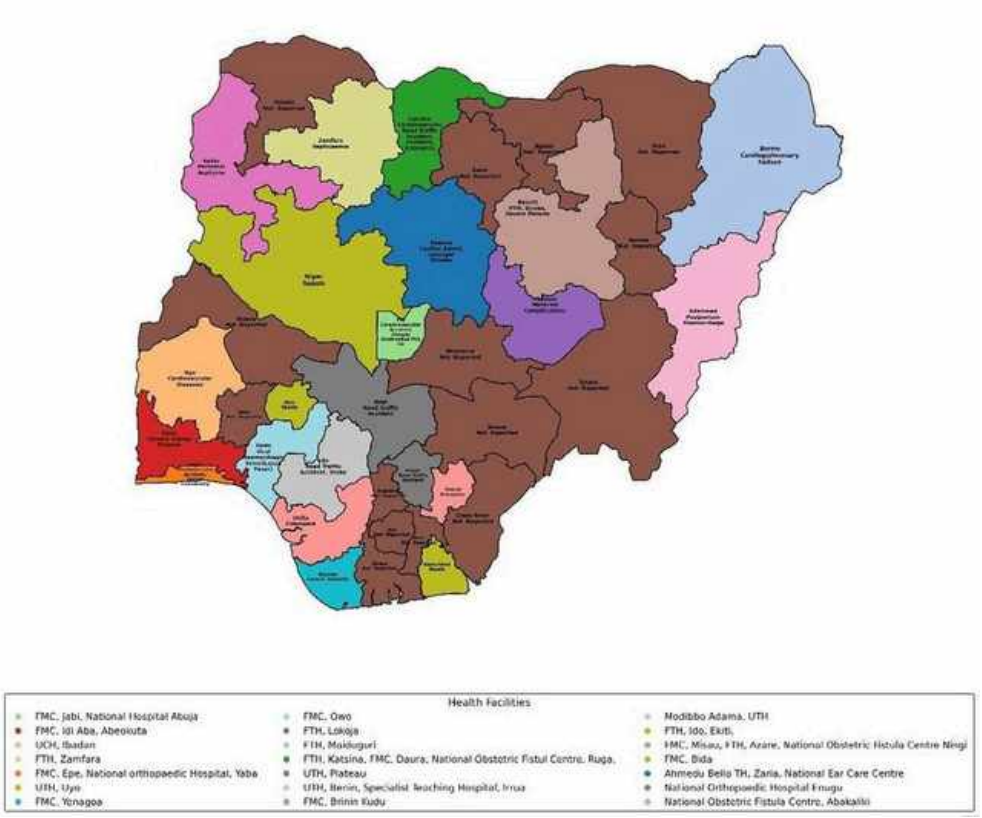


Figure 78

Leading Causes of Deaths as Reported by FTH/FMC: Source: Self-reported

Health Worker Force

Revitalize the End-End (Production - Retention) of Health Workers (Source: NHWF 2024)

Indicator	Value / Status
% number of licensed doctors currently engaged (public)	51%
% number of licensed nurses/midwives engaged (public)	78%
% number of licensed pharmacists engaged (public)	62%
% number of licensed Medical laboratory Professionals engaged (public)	70%
% number of licensed Comm. Health Practitioners CHEWS engaged (public)	100%
Number of doctors currently engaged (private)	8,392
Number of frontline health workers trained on integrated health care service	63,233
Number of SBAs recruited as Adhoc PHC staff	2,935

"Only 46% of births in Nigeria are attended by skilled health workers – strengthening the workforce saves mothers and newborns." – Source: Nigeria Demographic and Health Survey (NDHS) 2024

Table 5: Health Workforce Summary. **Source: (NHWF 2024)**

Cadre	Registered	Licensed	Licensing Ratio	% Female (Licensed)	Employed (% of Licensed)	Top 5 States (Density)	Bottom 5 States (Density)	External Migration	School Enrolment	Graduated
Comm. Health Practitioners	223,802	223,802**	100%	60%	100%	Nasarawa, Kwara , Gombe ,Benue , Plateau	Edo, Rivers, Delta, Lagos, FCT	13	40,080	35,846
Dental Surgery Technicians	14,682	11,472	78%	62%	80%	Kaduna, Ekiti, Enugu, Lagos, Kwara	Bauchi, Borno, Rivers, Akwa Ibom, Anambra	333	1807	1808
Dental Technologist	4276	264	6%	55%	35%	Enugu, Lagos, Ogun, Imo, Abia	Kano, Katsina, Adamawa, Kebbi, Bauchi	7	398	385
Dental Technology Officers	548	90	16%	67%	35%	Not Available	Not Available	Not Available	Not Available	Not Available
Dental Therapists	13,621	9,064	67%	62%	57%	Bayelsa, Kwara, Taraba, Ekiti, Lagos	Borno, Jigawa, Taraba, Zamfara, Sokoto	139	923	580
Dentists	5,722	3,559	62%	43%	47%	Lagos, FCT, Edo, Enugu, Rivers	Jigawa, Zamfara, Yobe, Borno, Kebbi	274	Not Available	280
Doctors	95,456	60,551	63%	37%	51%	FCT, Lagos, Abia, Edo, Enugu	Yobe, Zamfara, Katsina, Jigawa, Kebbi	3919	Not Available	4634
Health Records Officers	11,836	2730	23%	54%	26%	Lagos, FCT, Rivers, Enugu, Edo	Kebbi, Zamfara, Yobe, Borno, Sokoto	Not Available	8731	8205
Health Records Technicians	42,219	5,137	12%	60%	Not Available	FCT, Kebbi, Adamawa, Zamfara	Nasarawa, Lagos, Gombe, Plateau, Sokoto	Not Available	Not Available	Not Available
Medical Imaging Processing / X-ray Technicians	1214	486	40%	56%	90%	Ebonyi, Kwara, Adamawa,Nasarawa, Osun	Rivers, Niger, Gombe,Kogi, Zamfara	Not Available	1184	486
Medical Lab Professionals	47,315	7,008	15%	45%	70%	Lagos, Edo, Rivers, Delta, Enugu	Yobe, Kebbi, Zamfara, Borno, Sokoto	6861	Not Available	Not Available
Nurses	73,130	113,123	42%	86%	78%	FCT, Edo, Enugu, Delta, Bayelsa	Jigawa, Borno, Kano, Zamfara, Yobe	7487	41,196	36,374
Midwives	21,031									
Nurses with at least one other qualification	173,790									
Occupational Therapists	176	11	6%	45%	6%	Not Available	Not Available	21	Not Available	Not Available
Occupational Therapists Assistant	257	51	20%	45%	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Opticians	2976	307	10%	44%	45%	Nasarawa, Edo, Ekiti, Kwara, FCT	Zamfara, Benue, Sokoto,Borno, Bauchi	18	412	264
Optometrists	6,975	2,156	31%	63%	66%	FCT, Imo, Abia, Edo, Lagos	Katsina, Borno, Niger, Kebbi, Zamfara	431	393	440
Pharmacists	35,182	17,488	50%	44%	62%	Lagos, FCT, Enugu, Edo, Rivers	Sokoto, Kebbi, Borno, Zamfara, Yobe	702	3046	3632
Pharmacy Technicians	21,522	6,243	29%	64%	Not Available	Not Available	Not Available	Not Available	Not Available	3526
Physiotherapist Technicians	236	21	9%	43	9%	Not Available	Not Available	Not Available	Not Available	Not Available
Physiotherapists	8642	852	10%	55%	9%	Lagos, Enugu, Osun, Ogun, Ekiti	Bauchi, Niger, Benue, Delta, Katsina	658	Not Available	Not Available
Prosthetics & Orthotics	305	105	34%	41%	34%	Not Available	Not Available	15	Not Available	Not Available
Public Analysts	1,109	282	25%	41%	96%	Lagos, Imo, Enugu, Ogun, Cross River	Kwara, Jigawa, Katsina, Kebbi, Sokoto	20	89	19
Radiographers	4,632	2,810	61%	38%	97%	Lagos, FCT, Rivers, Enugu, Borno	Kogi, Zamfara, Taraba, Ondo, Ekiti	55	2178	892

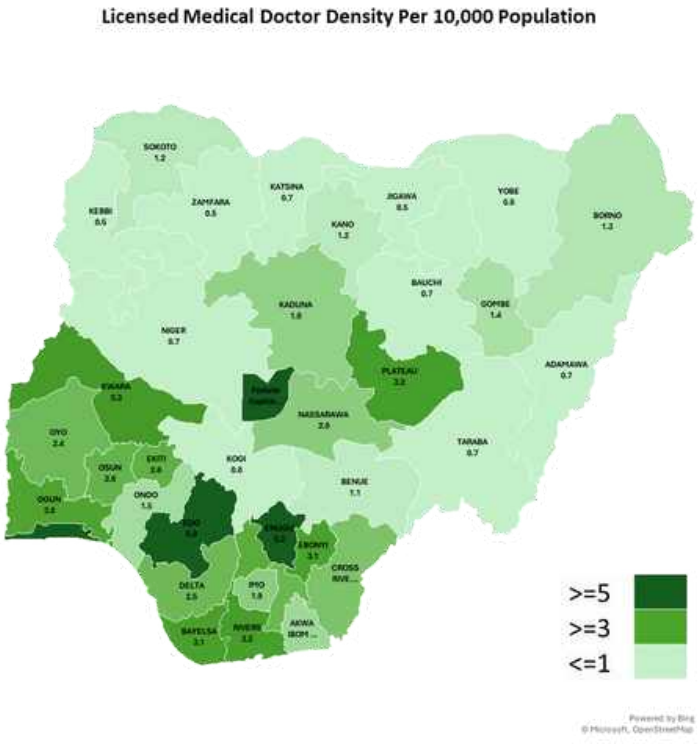


Figure 79

Medical doctors' density per 10,000 population in 2024

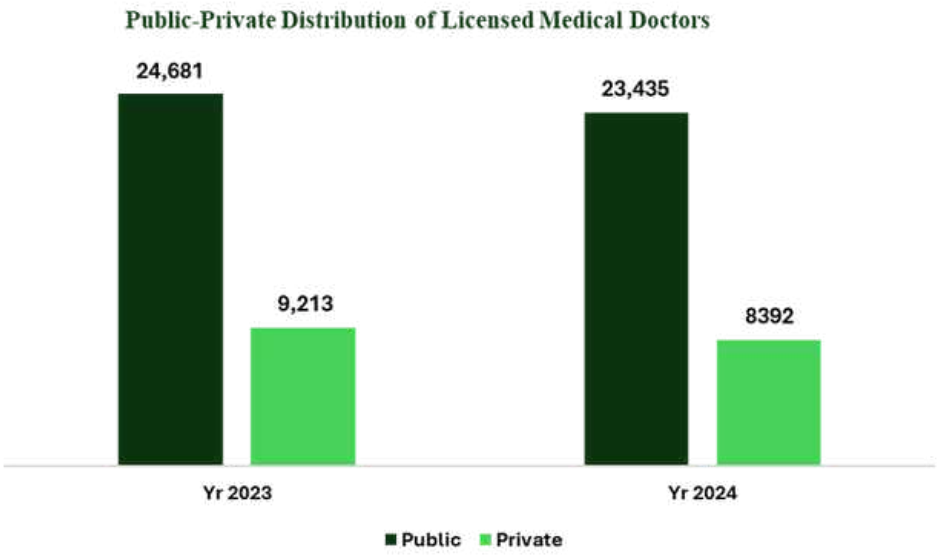
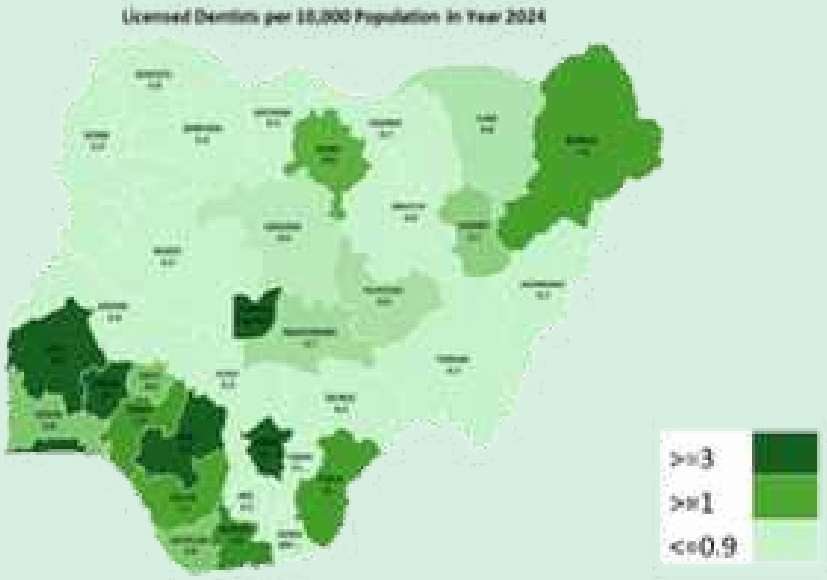


Figure 80

Public-private sector employment of licensed medical doctors between 2023 and 2024

Figure 81

Dentists density per 10,000 population in year 2024



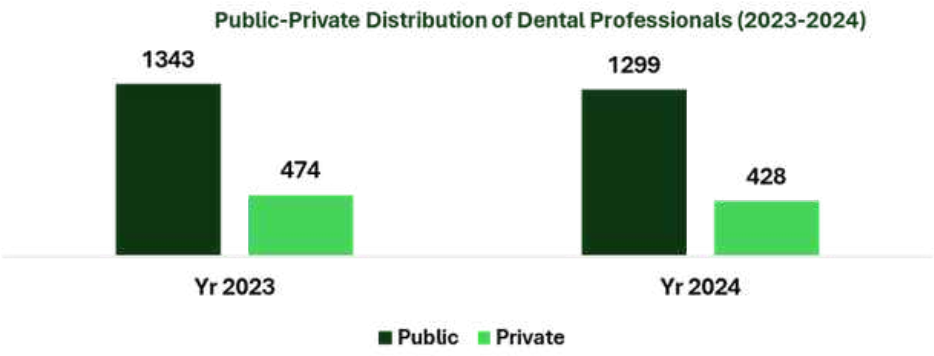


Figure 82

Public-private Distribution of Dental Professionals 2023-2024

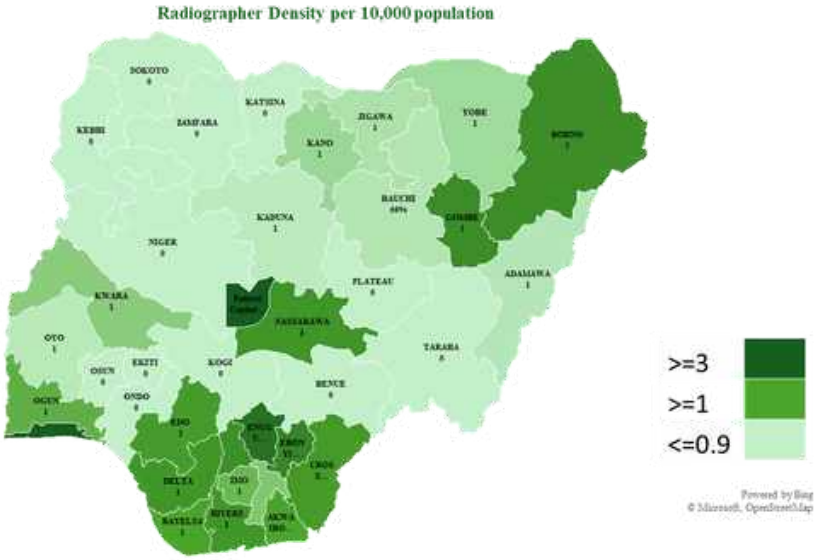


Figure 83

Radiographers density per 10,000 population in year 2024

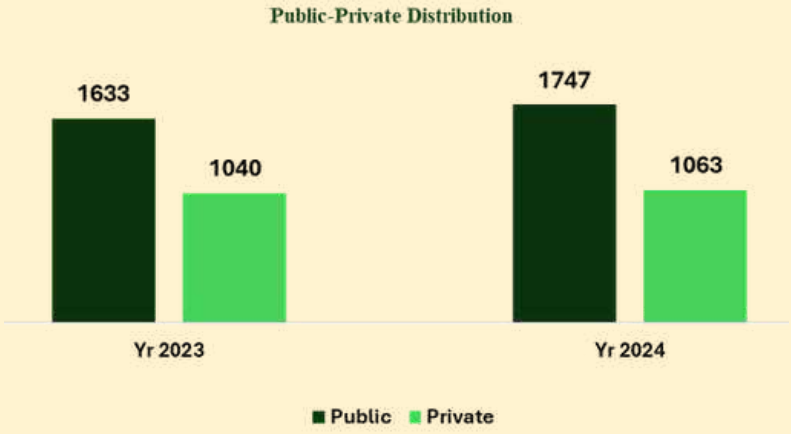


Figure 84

Public-private Distribution Licensed Radiographers (2023-2024)

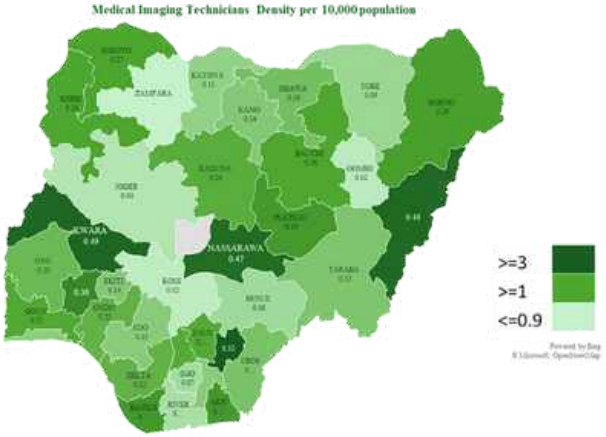


Figure 85

Medical Imaging Technicians density per 10,000 population in year 2024

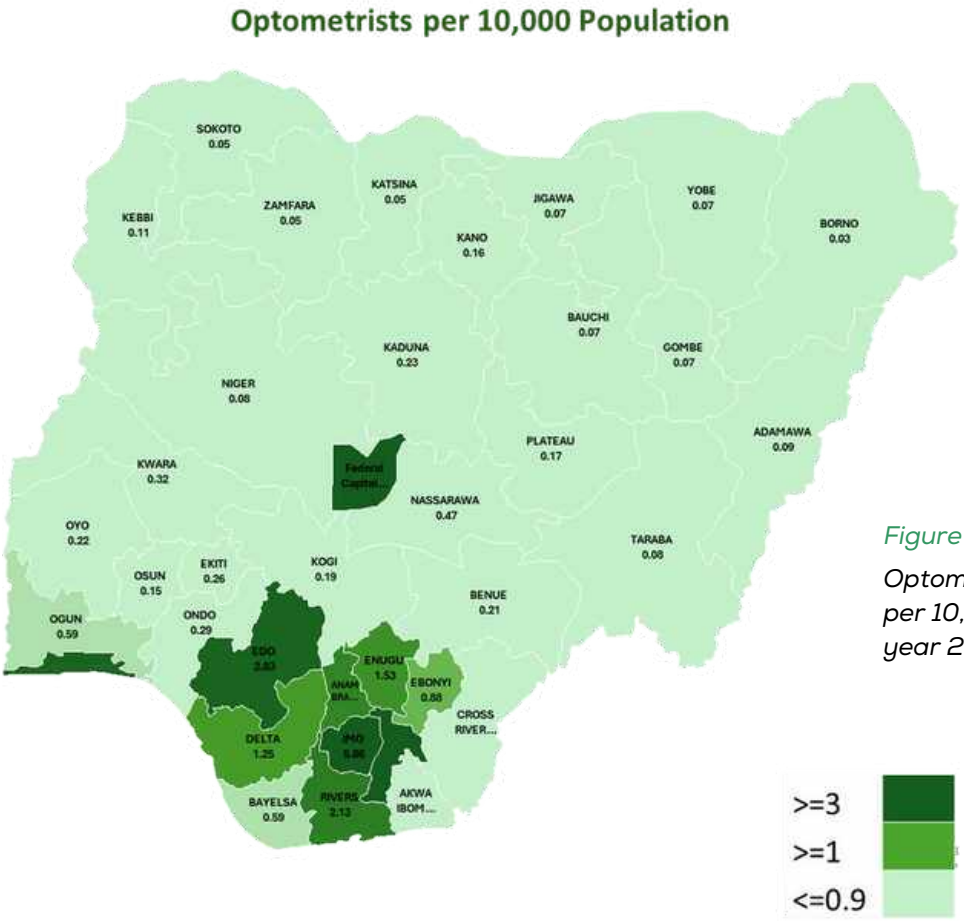


Figure 86

Optometrists density per 10,000 population in year 2024

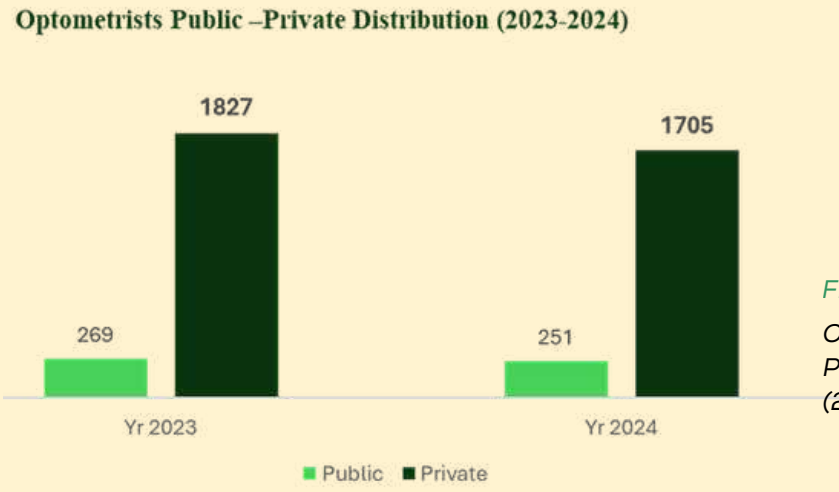


Figure 87

Optometrists Public – Private Distribution (2023-2024)

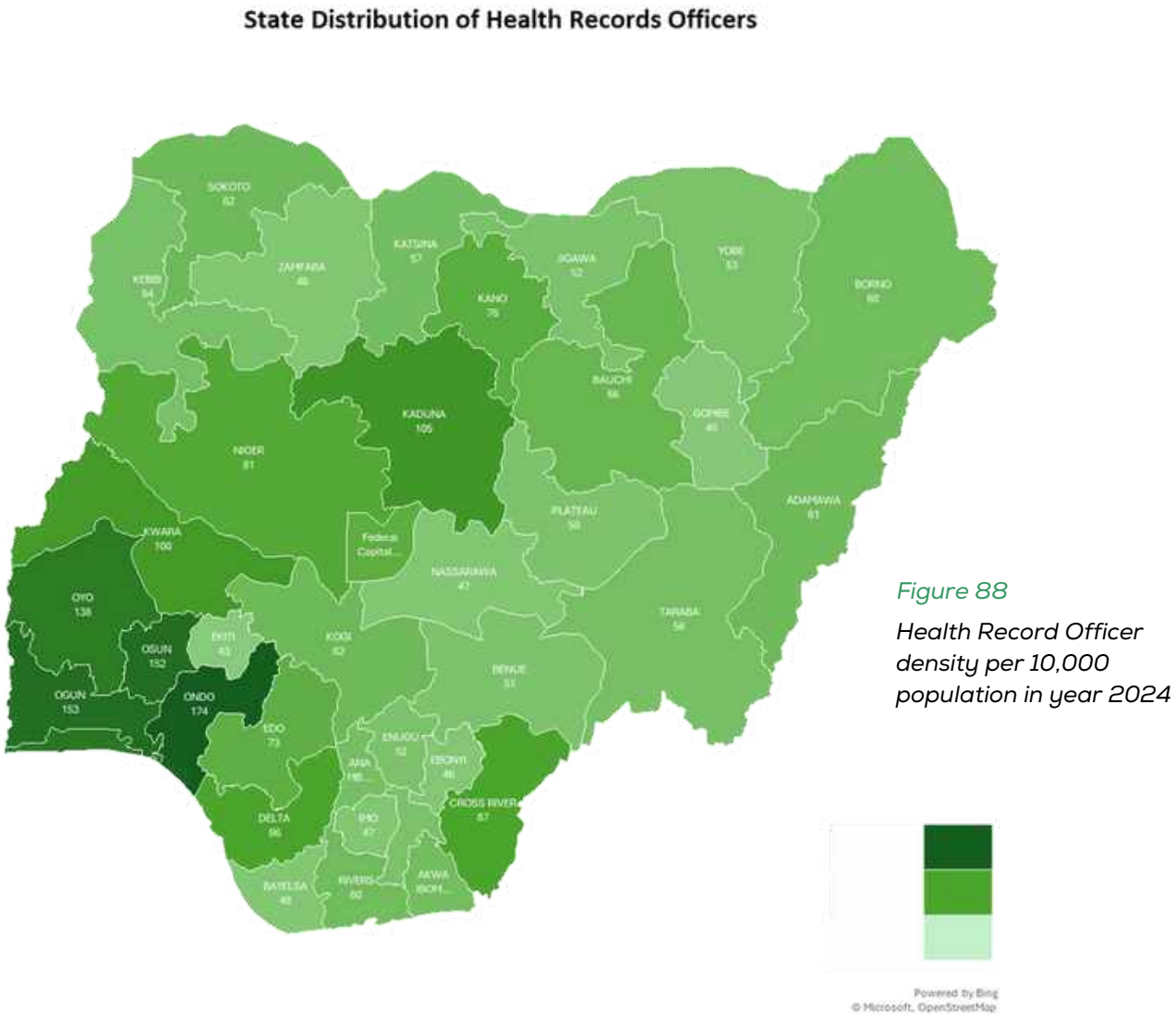


Figure 88

Health Record Officer density per 10,000 population in year 2024

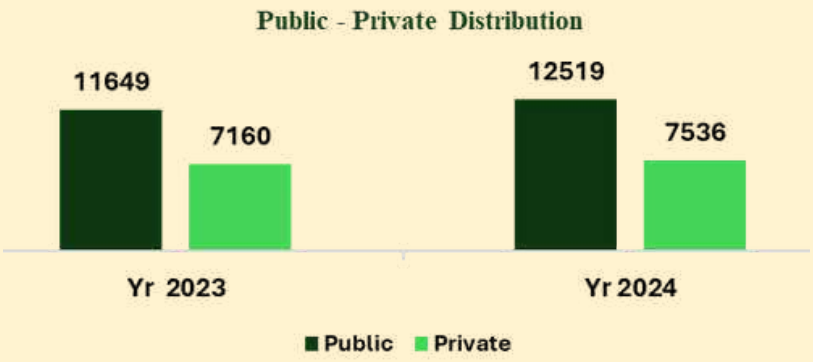


Figure 89

Health Record Officer Public –Private Distribution (2023-2024)

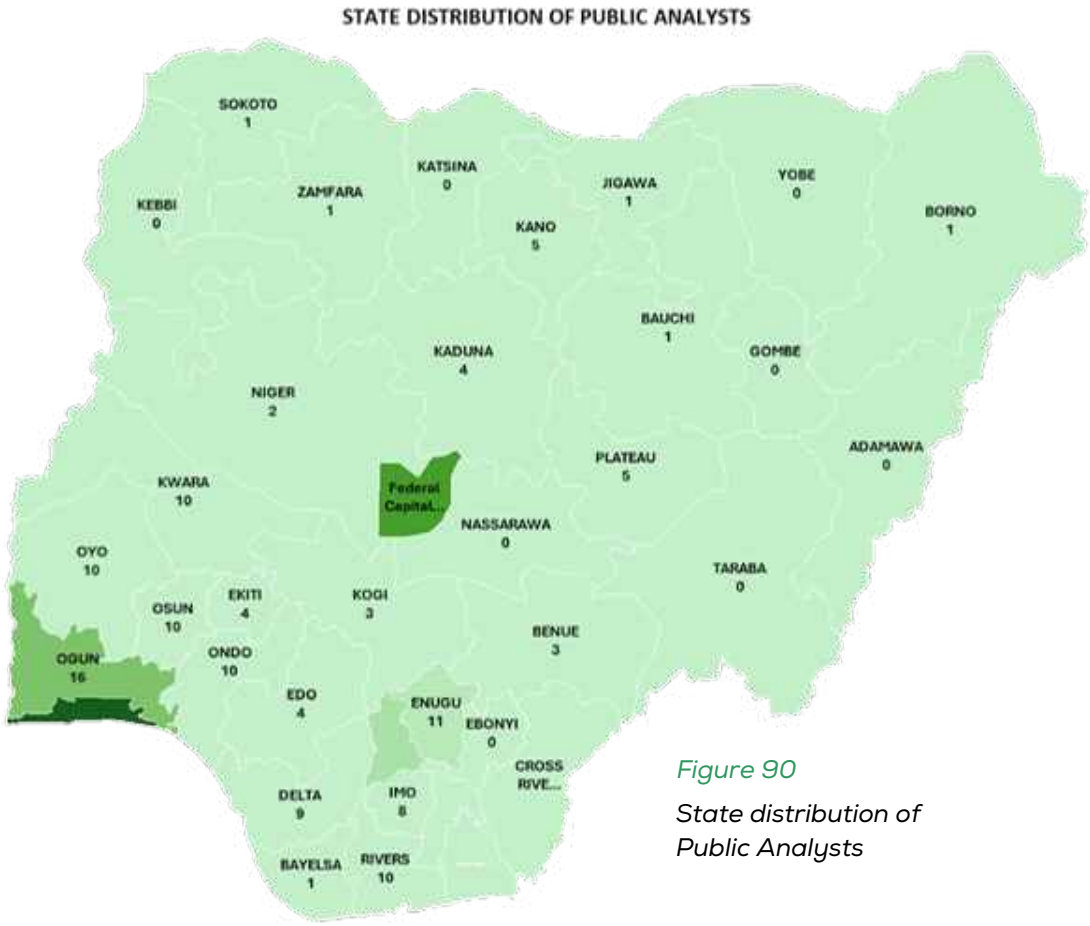


Figure 90

State distribution of Public Analysts

N.B: Urban-Rural Distribution of Licensed Public Analysts-There were no public analysts based in rural areas

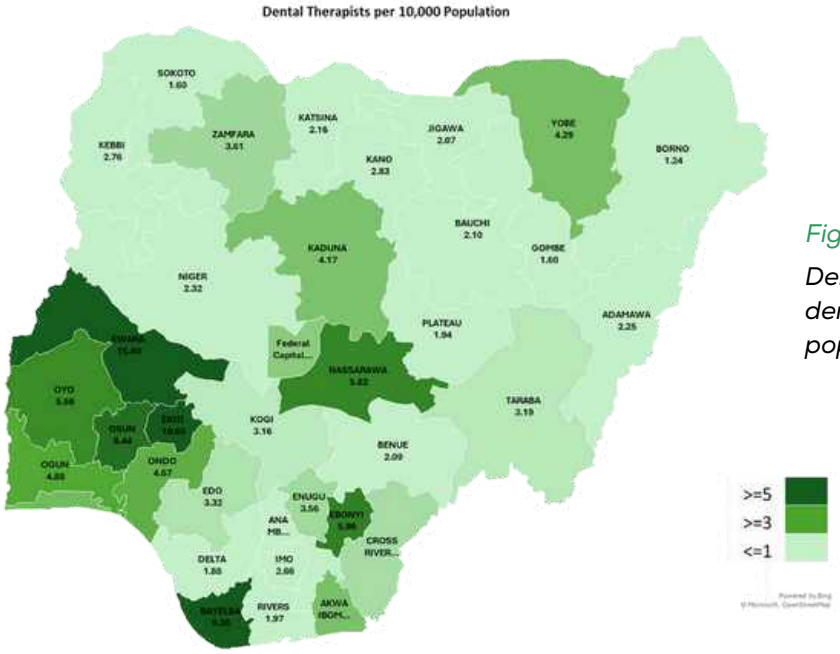


Figure 91

Dental Therapists density per 10,000 population in year 2024

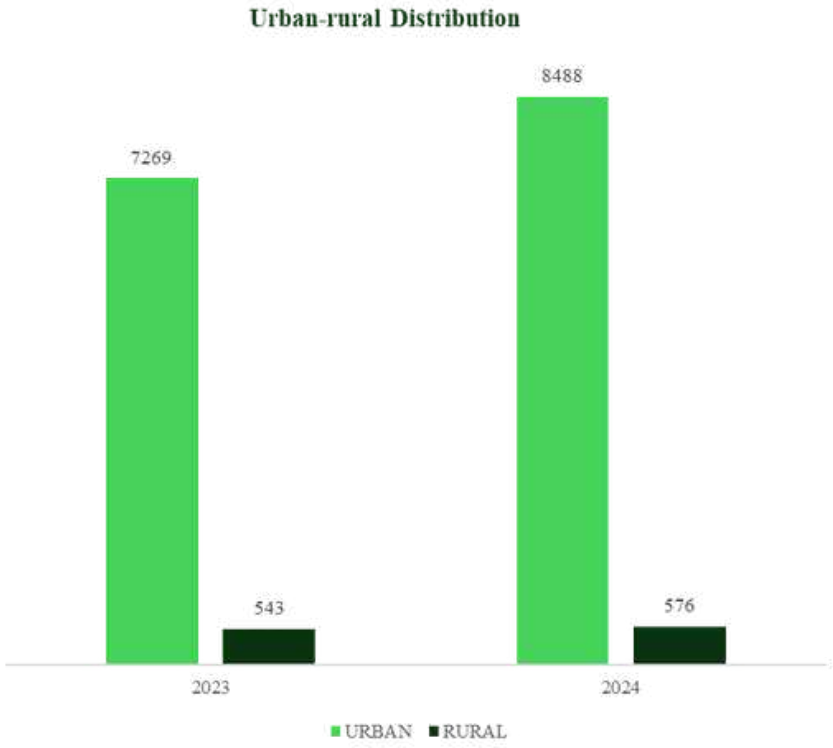


Figure 92

Dental Therapists Public –Private Distribution (2023-2024)

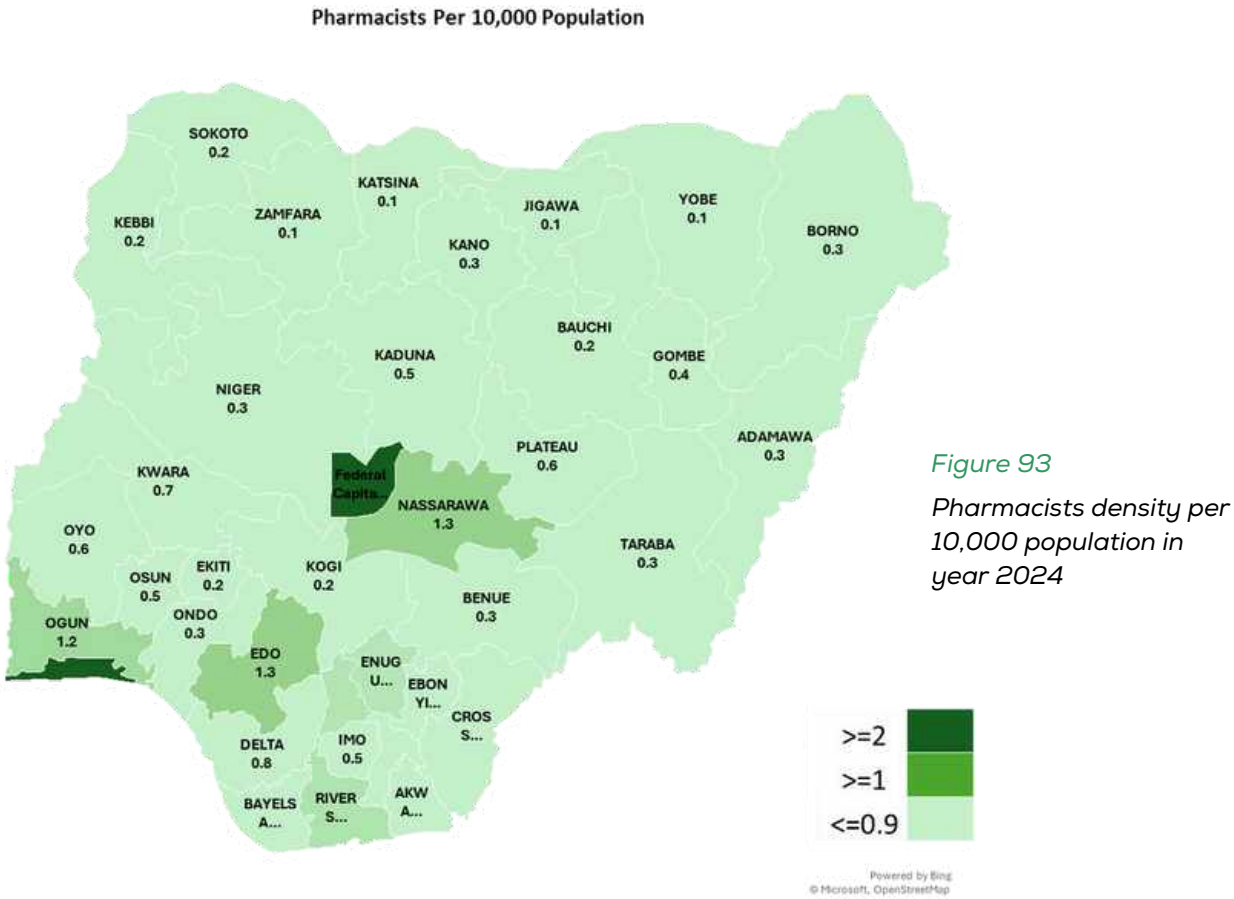


Figure 93

Pharmacists density per 10,000 population in year 2024

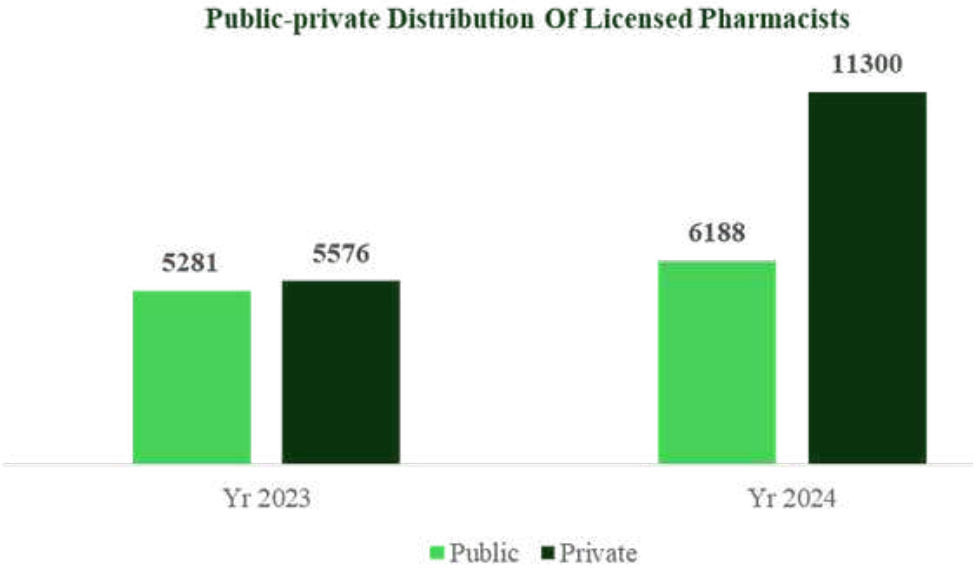


Figure 94

Public –Private Distribution of Licensed Pharmacists (2023-2024)

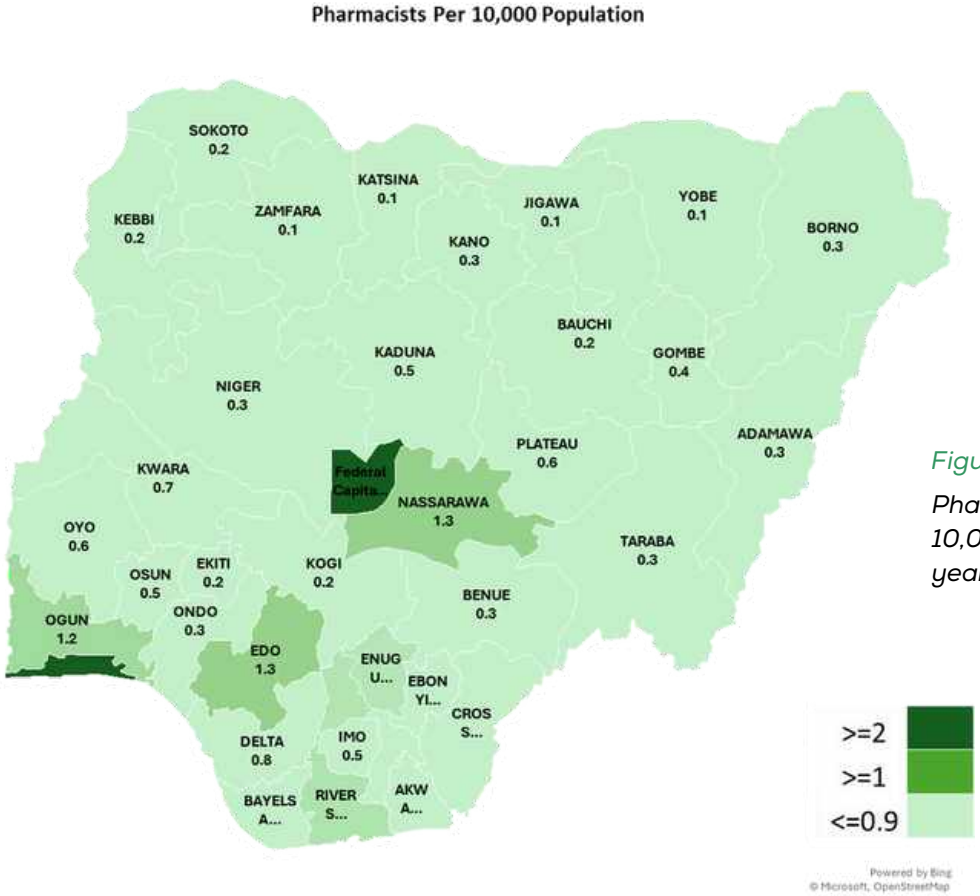


Figure 95

Pharmacists density per 10,000 population in year 2024

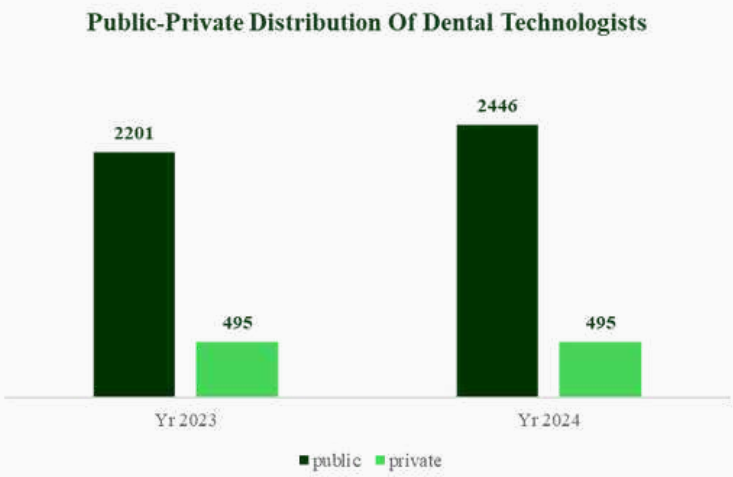


Figure 96

Public –Private Distribution of Dental Technologists (2023-2024)

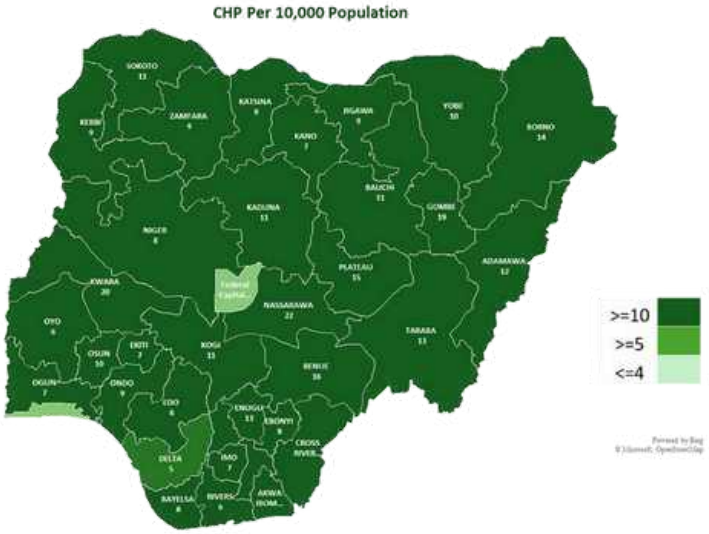


Figure 97

Community Health Practitioners density per 10,000 populationin year 2024

Figure 98

Public –Private Distribution of Community Health Practitioners (2023-2024)

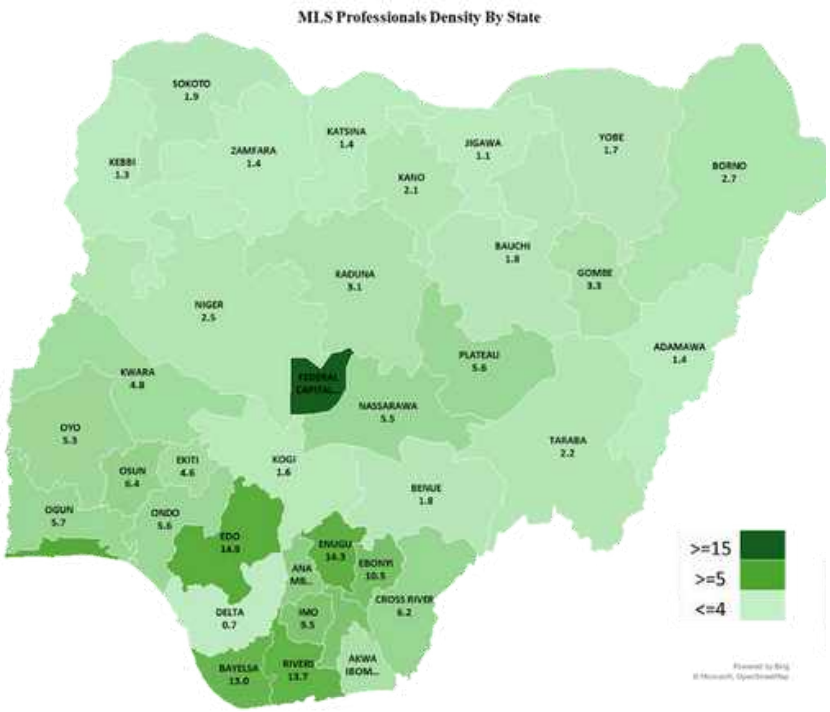


Figure 99

MLS Professional density per 10,000 population in year 2024

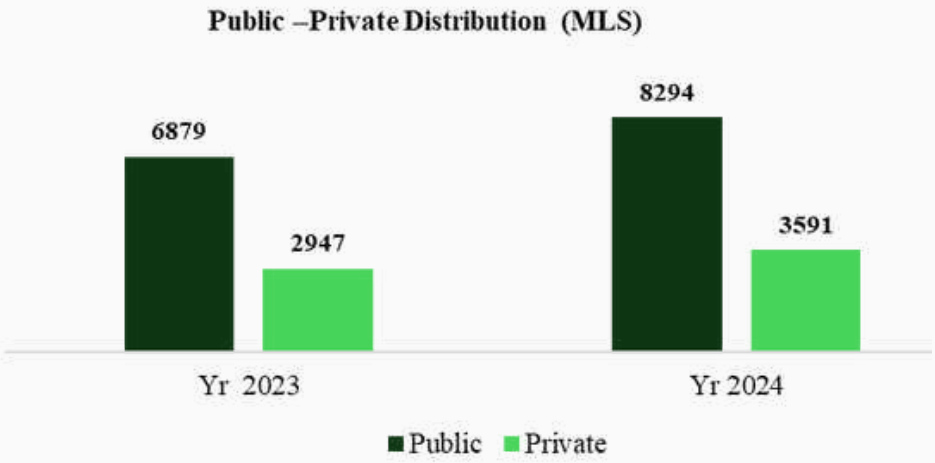


Figure 100

Public –Private Distribution of MLS Professionals (2023-2024)

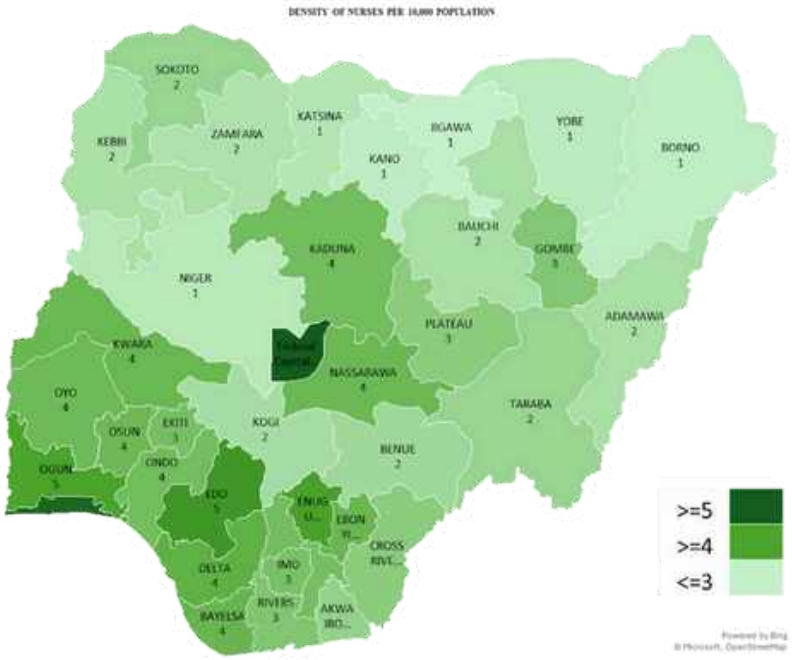


Figure 101

Density of Nurses per 10,000 population in year 2024

Nigeria's health workforce recorded steady growth between 2022 and 2024, across major professional groups, with notable increases in doctors (18%), nurses and midwives (13%), pharmacists (27%), and laboratory scientists (39%), reflecting expanded training capacity and policy reforms.

However, significant licensing gaps persist, only about half of registered professionals are actively licensed to practice highlighting regulatory bottlenecks and workforce underutilization. Despite these gains, rural–urban and sectoral disparities remain pronounced, with the majority of health workers concentrated in urban and public settings

Retention and Migration Trends

Attrition especially through external migration remains a significant challenge. External migration surged by 200 percent across all cadres between 2023 and 2024. In 2024 alone, a total of 4,193 doctors and dentists left Nigeria, with approximately 66 percent migrating to the United Kingdom. Nurses and midwives are the most affected group.

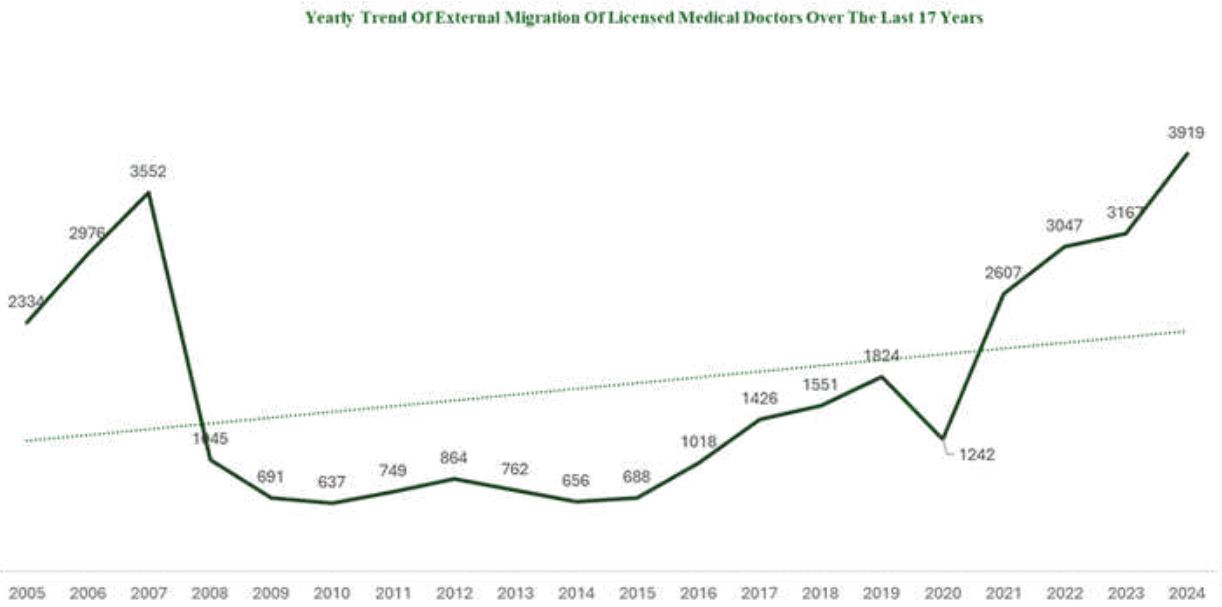


Figure 102: Yearly trend of licensed doctors migrating by year

Nigerian-trained doctors migrated internationally for employment opportunities, to the following countries e.g., UK, US, Canada, United States etc.

Top 10 Countries For Doctor And Dentist Migration (2023-2024)

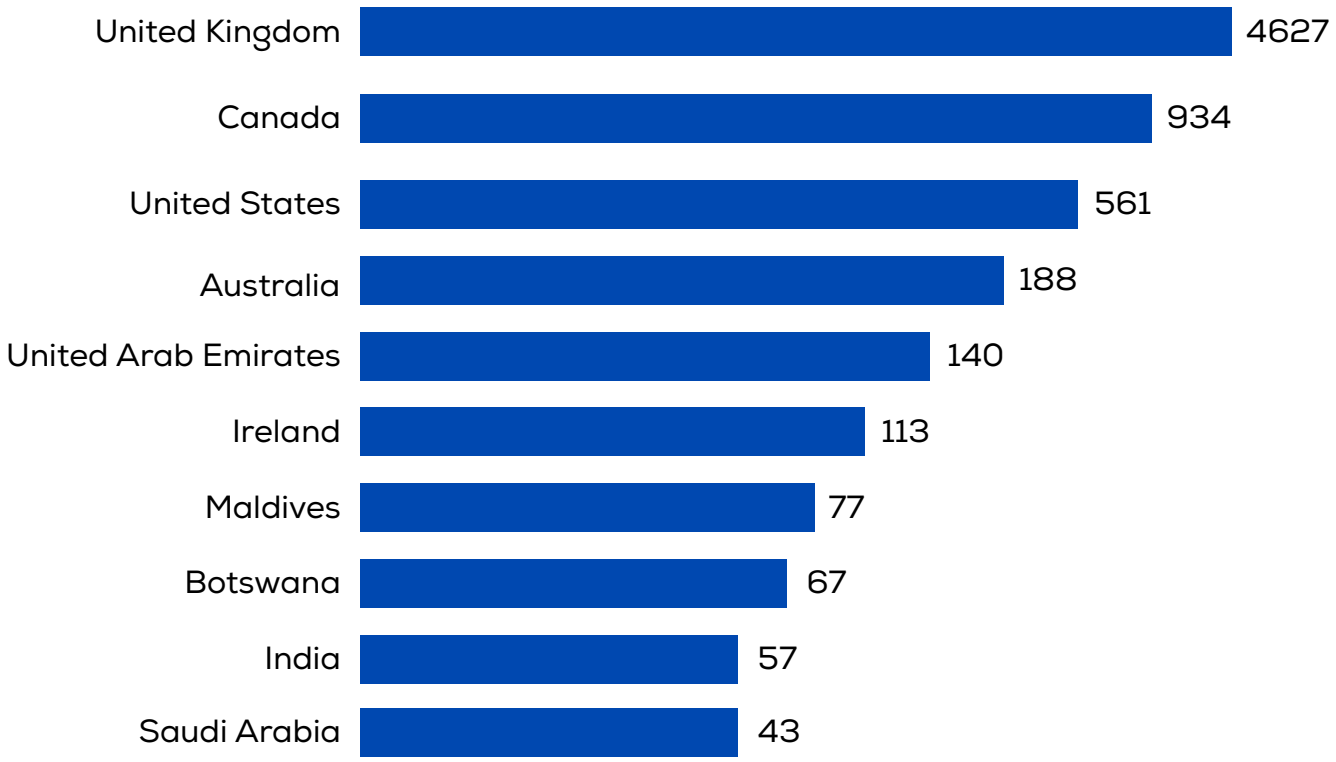
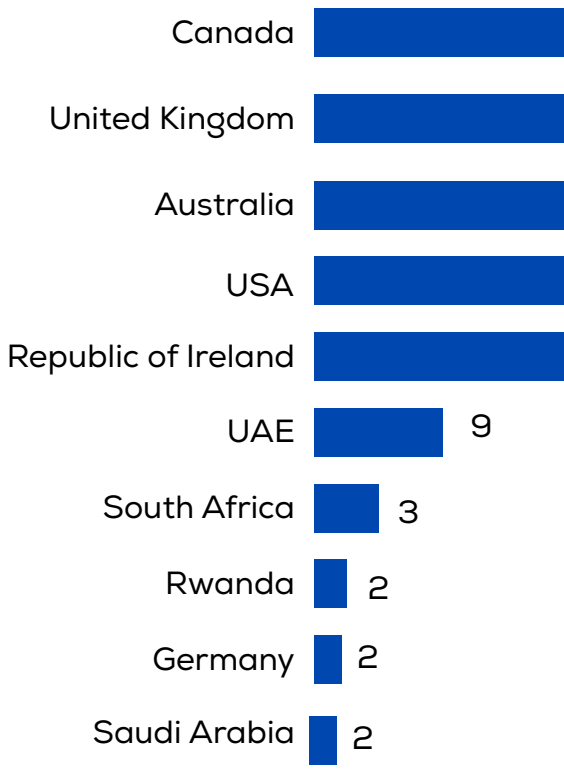


Figure 103: Top 10 Countries for Doctors and Dentist Migration

As of 2024, over 23,000 of nurses and midwives 702 , pharmacists and laboratory scientists 6,861 have also sought employment opportunities abroad.



Top Destinations Pharmacists (2023/2024)

Figure 104: Top 10 Countries for Pharmacists Migration

Top destinations of Nurses and Midwives (2023/2024)

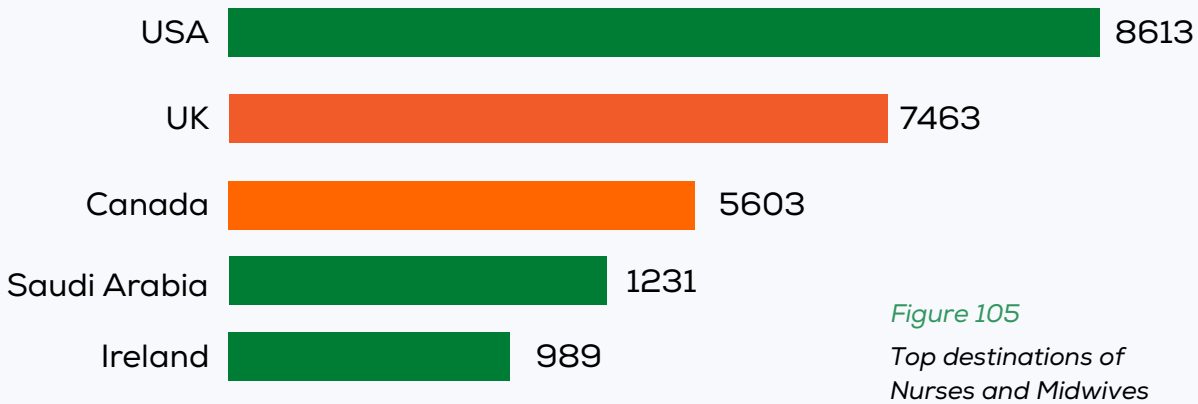


Figure 105

Top destinations of Nurses and Midwives

Top Destinations for all MLS Cadre (2023/2024)

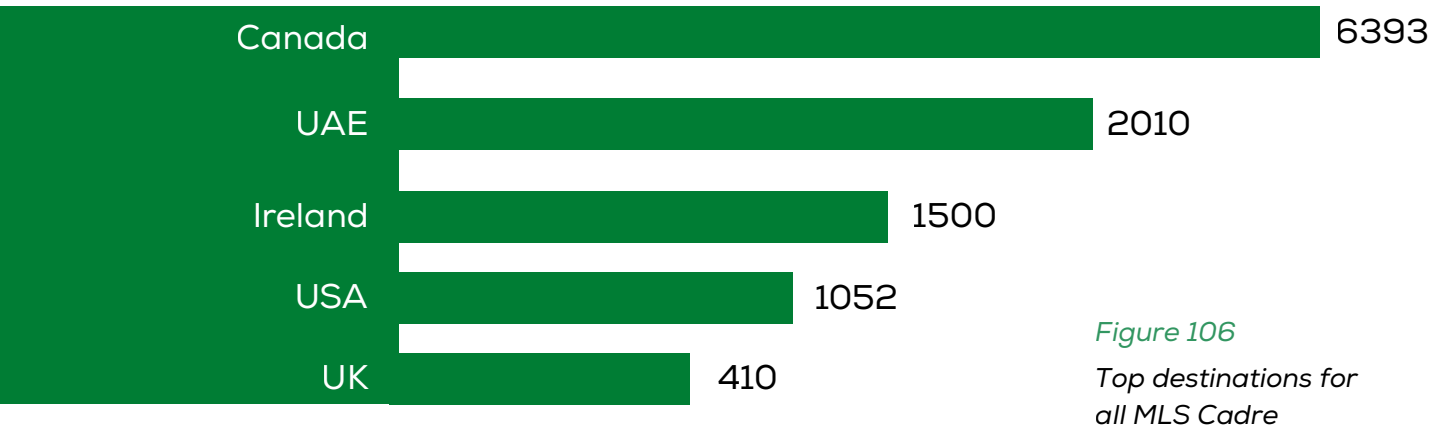


Figure 106

Top destinations for all MLS Cadre

Key Achievements

There was overall improvement in key maternal and reproductive health indicators in 2025, including ANC1, ANC4, skilled birth attendance, facility deliveries, use of partographs, and uptake of family planning services. These gains indicate progress in expanding access and improving the quality of RMNCAH+N services across the country. Routine data show modest improvements in vaccination coverage for specific antigens. The alignment of survey and routine data has strengthened performance monitoring, even though full immunization coverage remains below expected national targets.

Implementation of the malaria vaccine began in two states (Bayelsa and Kebbi), with expansion plans to four, marking a key milestone in malaria prevention. The HIV programme maintained high treatment success rates and showed a continued decline in incidence, underscoring sustained program effectiveness.

To combat Non-Communicable Diseases (NCDs), expanded screening for hypertension and diabetes cases increased in 2025. While moderate progress was achieved in reducing the number of LGAs and states requiring control measures, demonstrating continued advancement toward NTD elimination of Neglected Tropical Diseases (NTDs) goals.

Gaps and Bottlenecks

Key gaps in service delivery noted in 2025 include the paucity of registered blood banks required for quality blood and blood products that is crucial to the successful management of PPH, anemia especially in malaria, RTA, cancer treatment and other emergency conditions. Only 30 registered blood banks by the NBTS are reported across the country. Closely related is inadequate quality public and private laboratories across the country.

Similarly, emergency referrals are delayed or impossible due to the lack of emergency transport options especially in hard to reach areas. The continued use of ill-equipped vehicles for emergency medical transport poses a challenge to the quality of services.

Other key gaps noted include shortage of HRH, are continual use of TBA services and its attendant complications such as VVF, weak MPDSR systems in most facilities, as well as poor availability of critical life-saving medical supplies e.g ambu-bags, carbetocin, RUTF etc.

Recommendations

1. All laboratories in-country (public and private) are to register with NBTS to ensure timely access to safe, quality blood and blood products across the country.
2. The number of public and private ambulances that meet minimum standards should be increased in-country as part of the NEMSAS/SEMSAS program to aid emergency transportation especially in hard-to-reach areas.
3. States are to deploy trained MNCH frontline health workers to close the gap in SBA in PHCs, especially BHCPF supported facilities.
4. For sustainability, the HIV and TB National Programs to develop a 3-year transition into mainstream routine clinical health services. Other national programs to develop 5-year transition plans
5. Establish Human Resource for Health National Programs to respond to the significant gap in HRH.
6. Implement mechanisms to incentivize TBAs to undertake referral of women and children and penalize violators.

04

Unlocking the Health Value Chain

This section reviews the progress made under Pillar IV of the HSSB which is meant to unlock the value chain by promoting clinical research and development, shape markets to ensure sustainable local demands, and strengthen supply chains. To ensure speedy implementation, the Presidential Initiative for Unlocking the Healthcare Value Chain (PVAC) was established in October 2023. The goal is to make Nigeria a global hub for health products and technology by attracting new investments especially through private sector participation and cross-institutional collaboration. Specific objectives of the initiative is to boost the local production of pharmaceuticals, medical devices, and health technologies.

Promote Clinical Research and Development

Indicator	Value / Status
Number of ongoing R&D initiatives for local vaccine production	3
Number of clinical trials for vaccine development	0
Percentage of vaccine products analyzed	180%
Proportion of R&D outputs absorbed by local manufacturers of drugs, vaccines, and other health commodities	0%
Number of listed local herbal medicines and services utilized	168
Number of herbal medicines listed by NAFDAC on the National Essential Medicines List	240
Percent implementation of the National Roadmap for local production of health products	38% (Average)
Local universities and research institutions' participation in late-stage clinical trials	1

Shape markets to ensure sustainable local demand

Indicator	Value / Status
Quantity of RUTF produced locally	11,754.816 Metric tons
Quantity of malaria nets (LLINs) produced locally	0
Percentage increase in local production of tracer products for priority health programs	0
Number of local manufacturing plants producing new pharmaceuticals, medical supplies, diagnostics, and LLINs	2
Percent of WHO prequalified health products exported annually by Nigerian manufacturers	0
Number of products transitioned from importation-based sourcing to local production (NAFDAC 5+5 Policy)	66
Percentage of locally produced medicines and health commodities in public procurement	38% (Avg)

Nigeria's pharmaceutical and health commodities market shows a mixed picture of progress and gaps. While the total number of local pharmaceutical manufacturing companies is still being validated through PVAC, some achievements are evident. In 2025, 11,754.816 metric tons of Ready-to-Use Therapeutic Food (RUTF) were produced locally. Sixty-six 66 products transitioned from importation-based sourcing to local production under the NAFDAC 5+5 Policy, reflecting incremental progress in self-reliance. Furthermore, 38% of medicines and health commodities procured publicly were locally produced, signaling a growing role for domestic manufacturers in meeting national demand.

Strengthen Supply Chains

Indicator	Value / Status
% of States with a functional central medical stores/warehouses	59%
Reporting rate	30%
Flagged reports	16%
Stock-out rate	30%
Months of stock	46 products with less than 2 MOS
Average monthly consumption	60 products with greater than 20% change
Order fill rate	3%
Expiries	622 units

Infrastructure Upgrades for Pharma-Grade Storage

Number of warehouses upgraded to Pharma Grade	22

Key Achievements

The health sector is actively strengthening Nigeria's clinical research capacity through strategic planning, regulatory framework development, and targeted capacity-building initiatives. Significant progress has been made towards ensuring that new manufacturers of essential medicines, commodities and diagnostics obtain WHO pre-qualification through PVAC intervention. Support is also being provided to local manufacturers of RDTs, malaria bed-nets, syringes, RUTF, and other medical commodities.

Specifically, the Ministry, through its presidential initiative, has curated a robust pipeline of over 85 viable projects with a total investment value exceeding $5 billion. To finance these, a $1 billion facility has been raised from the African Export-Import Bank (Afreximbank), with another €1 billion commitment from the European Investment Bank (EIB). Additional local capital commitments from the Nigeria Sovereign Investment Authority (NSIA) and the Bank of Industry (BOI).

Ten (10) strategic Memoranda of Understanding (MoUs) with leading global pharmaceutical companies, technology owners, and health partners. Key highlights include:

Vestergaard
Scheduled to break ground on a new manufacturing facility on October 15th, 2025 for the manufacturing of dual active-ingredient Long Lasting Insecticidal Nets – making Nigeria the first African country to accomplish this feat.

Abbott & Wondfo
Respective collaborations towards local manufacturing of RDTs

Siemens Healthineers
Collaboration towards local manufacturing of ultrasound technology

Zipline
Signed at the 79th UNGA, now working towards deployment of drone technology for the distribution of medical commodities and vaccines to Primary Health Centers nationwide.

Nigeria is an active participant in the World Health Organization (WHO) - Medicines Patent Pool (MPP) mRNA Technology Transfer program, building domestic capacity for advanced mRNA vaccine research and development towards manufacturing.

PVAC has laid the foundation for talent development through Train-the-Trainer programs on vaccine development and have established a Pharmaceutical Training Academy to upskill the national workforce.

Nigeria is currently implementing a 2-year Executive Order that waives import duty and taxes on essential raw materials and equipment for local pharmaceutical production. This has provided import duty exemptions for raw materials and essential production inputs over the last three months. This policy intervention has directly benefited 47 local pharmaceutical manufacturers, reducing their production costs and enhancing competitiveness.

The Nigeria Clinical Trials Consortium (NCTC) to streamline and promote clinical research. An investment case has been developed to upgrade clinical trial infrastructure nationwide, which will position Nigeria as a regional hub for clinical research and pharmaceutical R&D. By 2034, a total of 437 clinical trial centers is expected to be developed and are projected to produce a revenue of $3.8 billion.

To improve market shaping and efficiency, we are operationalizing Medipool under a PPP framework as a national group purchasing platform for health commodities, which will aggregate demand and reduce procurement costs. This multi-faceted approach demonstrates the Federal Government's strong commitment to achieving vaccine security, self-sufficiency in essential medicines, and positioning Nigeria as a regional healthcare manufacturing hub.

The National Products Supply Chain Management Programme (NPSCMP) introduced the Integrated QA/QC Protocol for ATM Commodities a robust protocol for Quality Assurance and Quality Control of Antimalarial, Tuberculosis, and HIV commodities to curb the circulation of substandard and falsified medicines, ensuring that health products used in Nigeria are safe and of high quality.
Notably, this led to the implementation of the country's first-ever integrated QA/QC. In collaboration with People that Deliver (PtD) through ARC-ESM, NPSCMP is adopting the Global Human Resource for Supply Chain (HR4SC) Professionalization Framework. A tailored roadmap, adapted from PtD's global frameworks, has been developed to guide the professionalization journey in-country. Once formally adopted, this roadmap will evolve into a comprehensive implementation plan, setting the stage for a more skilled, recognized, and productive supply chain workforce across Nigeria.

The NPSCMP also developed a Supply Chain Integration Process Framework, a standardized guide for harmonizing supply chain operations, particularly at the last mile. This framework is geared toward enhancing cost-effectiveness, operational efficiency, and equitable access to health commodities

To enhance stock visibility and data-driven supply chain management in Nigeria, NPSCMP in a significant expansion of NHLMIS has onboarded essential medicines, marking a critical step toward integrating public health commodities with essential medicine supply chains. In addition, the introduction of Electronic Proof of Delivery (ePOD) on NHLMIS–has significantly improved operational efficiency and end-to-end visibility of health products at subnational levels. This initiative has strengthened the capacity of health facilities to report accurate data.

Gaps and Bottlenecks

Non-release of budgetary allocations by the government has interrupted critical supply chain projects implementation. Furthermore, structural gaps persist across the states. Eleven states are yet to establish Drug Management Agencies (DMAs), a key component for effective pharmaceutical governance. In addition, sixteen state Central Medical Stores (CMS) remain below pharma-grade standards, limiting their capacity to store and distribute medical products safely and efficiently.

Recommendations

Non-release of budgetary allocations by the government has interrupted critical supply chain projects implementation. Furthermore, structural gaps persist across the states. Eleven states are yet to establish Drug Management Agencies (DMAs), a key component for effective pharmaceutical governance. In addition, sixteen state Central Medical Stores (CMS) remain below pharma-grade standards, limiting their capacity to store and distribute medical products safely and efficiently.

The gains made by PVAC in resource mobilization and efforts at local manufacturing should be sustained. However, government should expedite the release of approved appropriation funds to enable the implementation of NPSMCP activities to minimize over reliance on donor funding. Strategic support should be provided to the remaining eleven states to facilitate the establishment of Drug Management Agencies.

The sixteen state CMS facilities should be upgraded to meet pharma-grade standards, ensuring compliance with safety and quality requirements for medical storage and distribution.

05

Health Security

This section reviews the progress made under Pillar IV of the HSSB which focuses on the health sector's ability to detect, prevent and respond to public health threats, and build climate resiliency for the health system in collaboration with other sectors.

Ability to detect, prevent and respond to public health threats

National Surveillance Systems (IDSR/e-IDSR)

Percentage of States with fully functional PHEOCs **86%**

Percentage of IDSR points reporting electronically **100%**

Number of Disease outbreaks recorded **17**

% of states implementing collaborative surveillance with digitalized recording and reporting of public health threats using one health approach **49**

Number of sentinel sites reporting monthly and AMR surveillance data **5**

Number of laboratories (at National, state, and Zonal) with expanded diagnostics capacity to test all priority pathogens **31**

Figure 107: State that meet the minimum standards for PHEOCs functionality

Epidemic Response (Lassa fever, cholera, etc.)

% of emerging public health threats prevented in a timely manner	33%
Number of health security staff (health care workers and others) trained on public health emergency management based on One Health approach	127

Priority Disease Situation Analysis 2025 (Q1 – Q3)

Table 6: Priority Disease Outbreak in Q1

Priority Disease Outbreaks: January – March

Disease	States (Suspected Cases)	States	Confirmed Cases	Deaths / Suspected Cases
Lassa Fever	Ondo, Bauchi, Edo, Taraba, Ebonyi, Kogi, Gombe, Plateau, Benue, Nasarawa, Delta, Cross River, Enugu, Anambra	14	563	103
CSM	Kebbi, Katsina, Yobe, Gombe, Sokoto, Borno, Adamawa, Oyo, Bauchi, Ebonyi, Ondo, Kaduna, Plateau, Kano, Osun, FCT, Ekiti, Benue, Akwa Ibom, Niger, Bayelsa, Anambra	22	69	76
Cholera	Bayelsa, Rivers, Abia, Delta, Niger, Akwa-Ibom, Benue, Katsina, Bauchi, Kogi, Kebbi, Gombe, Adamawa, Ekiti, Imo, Ondo, Nasarawa, Osun, Borno, Enugu, Lagos, Oyo, Sokoto, Yobe, Taraba	25	74	28

Table 7: Priority Disease Outbreak in Q2

Priority Disease Outbreaks: April – June

Disease	States (Suspected Cases)	States	Confirmed Cases	Deaths / Suspected Cases
Diphtheria	Akwa-Ibom, Bauchi, Edo, Gombe, Imo. Kaduna, Kano, Katsina, Lagos, Ogun, Plateau & Sokoto	12	335	21
Cholera	Adamawa, Lagos, Plateau, Bauchi, Benue, Ebonyi, Enugu, Katsina, Kaduna, Delta, Kogi, Cross River, Imo, Abia, Ondo, Gombe, Akwa Ibom, Yobe, Ogun, FCT, Edo, Zamfara, Ekiti	23	6	14
Measles	Abia, Adamawa, Akwa Ibom, Anambra, Bauchi, Bayelsa, Benue, Borno, Cross River, Delta, Ebonyi, Edo, Ekiti, Enugu, Gombe, Imo, Jigawa, Kaduna, Kano, Katsina, Kogi, Kwara, Lagos, Nasarawa, Ogun, Ondo, Osun, Oyo, Plateau, Rivers, Taraba, Yobe, Zamfara	33	146	0
	Abia, Adamawa, Akwa Ibom, Bauchi, Benue, Borno, Delta, Ebonyi, Edo, Ekiti, Enugu, Gombe, Imo, Jigawa, Kaduna, Kano, Katsina, Kebbi, Kogi, Lagos, Niger, Ondo, Plateau, Sokoto, Yobe, Zamfara	26	120	61
Lassa Fever	Ondo, Edo, Bauchi, Taraba, Ebonyi, Plateau, Gombe, Kogi, Borno, Kaduna, Ogun, Delta, Cross River, Enugu, FCT, Anambra, Benue, Nasarawa	18	99	19
Mpox	Akwa Ibom, Anambra, Bauchi, Bayelsa, Benue, Cross River, Delta, Edo, Ekiti, Enugu, FCT, Gombe, Imo, Jigawa, Kaduna, Kebbi, Kogi, Lagos, Nasarawa, Ogun, Ondo, Osun, Plateau, Rivers, Zamfara	25	65	1
Rabies	FCT	1	3	1
Yellow Fever	Abia, Adamawa, Akwa Ibom, Anambra, Bauchi, Bayelsa, Benue, Borno, Delta, Ebonyi, Edo, Ekiti, Enugu, Gombe, FCT, Imo, Jigawa, Kaduna, Kano, Katsina, Kogi, Kwara, Lagos, Nasarawa, Niger, Ogun, Ondo, Osun, Oyo, Plateau, Rivers, Sokoto, Taraba, Yobe	34	3	0

Table 8: Priority Disease Outbreak in Q3

Priority Disease Outbreaks: July – September				
Disease	*States (Suspected Cases)*	*State (Suspected Cases)*	*Confirmed Cases*	*Deaths / Suspected Cases*
Diphtheria	Abia, Adamawa, Akwa Ibom, Anambra, Bauchi, Benue, Borno, Delta, Edo, Enugu, Gombe, Kaduna, Katsina, Kebbi, Kwara, Nasarawa, Imo, Jigawa, Niger, Ogun, Oyo, Plateau, Rivers, Sokoto, Yobe, Zamfara, FCT	28	3439	340
Cholera	Abia, Anambra, Benue, Borno, Ebonyi, Ekiti, Enugu, FCT, Gombe, Imo, Jigawa, Kaduna, Kano, Katsina, Kogi, Lagos, Nasarawa, Niger, Ogun, Ondo, Osun, Oyo, Plateau, Rivers, Yobe	29	45	196
Measles	Abia, Adamawa, Akwa Ibom, Anambra, Bauchi, Bayelsa, Benue, Borno, Cross River, Delta, Ebonyi, Edo, Ekiti, Enugu, Gombe, Imo, Jigawa, Kaduna, Kano, Katsina, Kebbi, Kogi, Kwar,a, Lagos, Nasarawa, Ogun, Ondo, Osun, Oyo, Plateau, Rivers, Sokoto, Taraba, Yobe, Zamfara, FCT	36	255	0
Dengue	Edo, Sokoto	2	195	0
Yellow Fever	Abia, Adamawa, Akwa Ibom, Anambra, Bauchi, Bayelsa, Benue, Borno, Cross River, Delta, Ebonyi, Edo, Ekiti, Enugu, Gombe, Imo, Jigawa, Kaduna, Kano, Katsina, Kebbi, Kogi, Kwara, Lagos, Nasarawa, Niger, Ogun, Ondo, Osun, Oyo, Plateau, Rivers, Sokoto, Taraba, Yobe, Zamfara, FCT	37	0	1
Cerebrospinal Meningitis	Adamawa, Anambra, Bauchi, Benue, Borno, Delta, Ebonyi, Enugu, Ekiti, Gombe, Jigawa,	23	0	8
	Kaduna, Kano, Katsina, Nasarawa, Niger, Ogun, Ondo, Osun, Oyo, Plateau, Sokoto,			
	Yobe			

Table 9: Summary of Priority Disease Outbreak (Q1-Q3)

Quarter	Disease	Suspected Cases	Confirmation Rate
Q1	3	4,956	14.20%
Q2	8	8,363	12.70%
Q3	6	13,285	29.60%

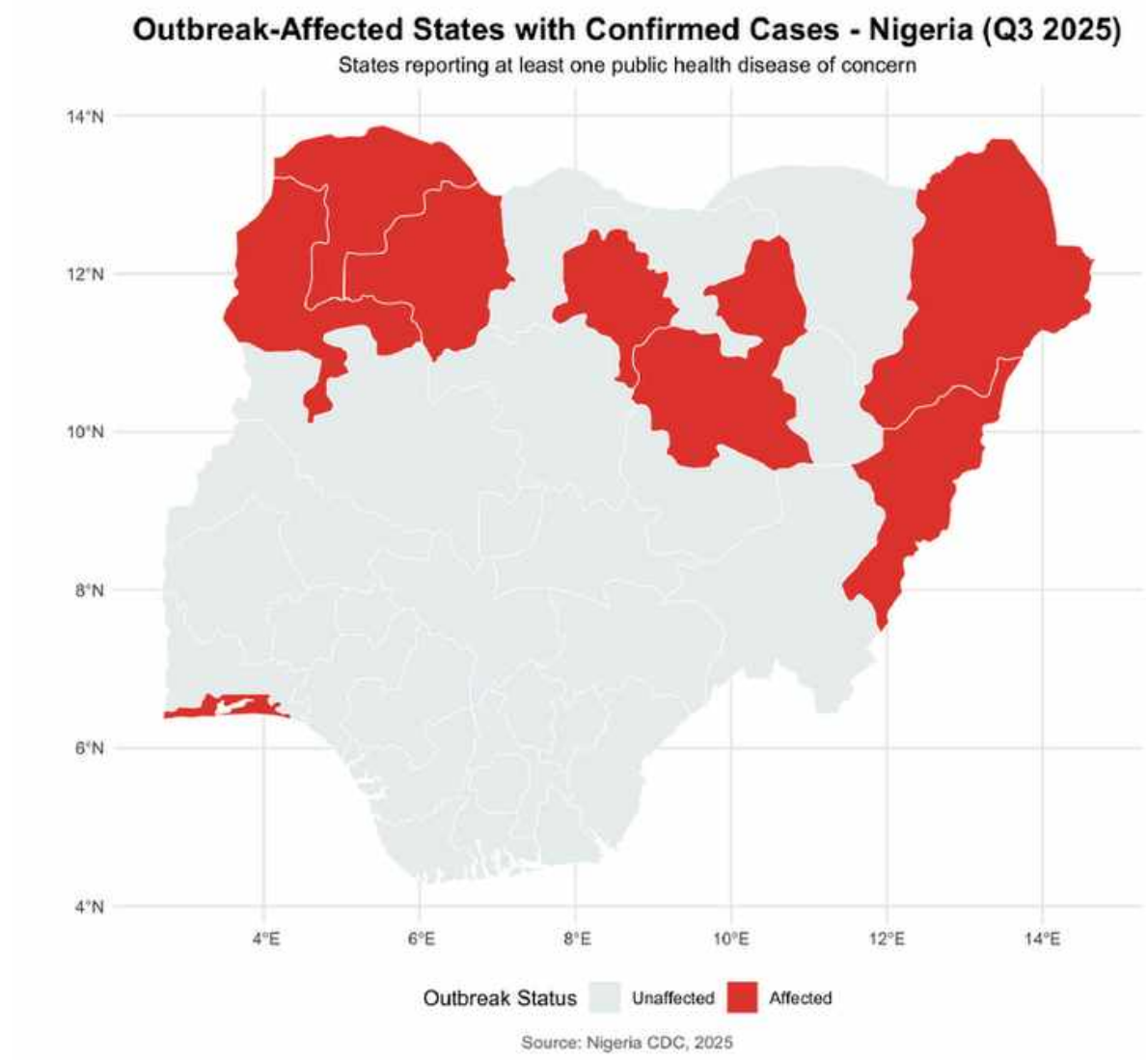


Table 10: Outbreak-affected States with confirmed cases

The table and figure above highlights persistent public health vulnerabilities in the year within most States, with repeated occurrences of diphtheria, cholera, measles and other preventable infections. The key questions borders on how we can strengthen surveillance, vaccination coverage, and rapid response systems to prevent recurring outbreaks and improve national epidemic preparedness.

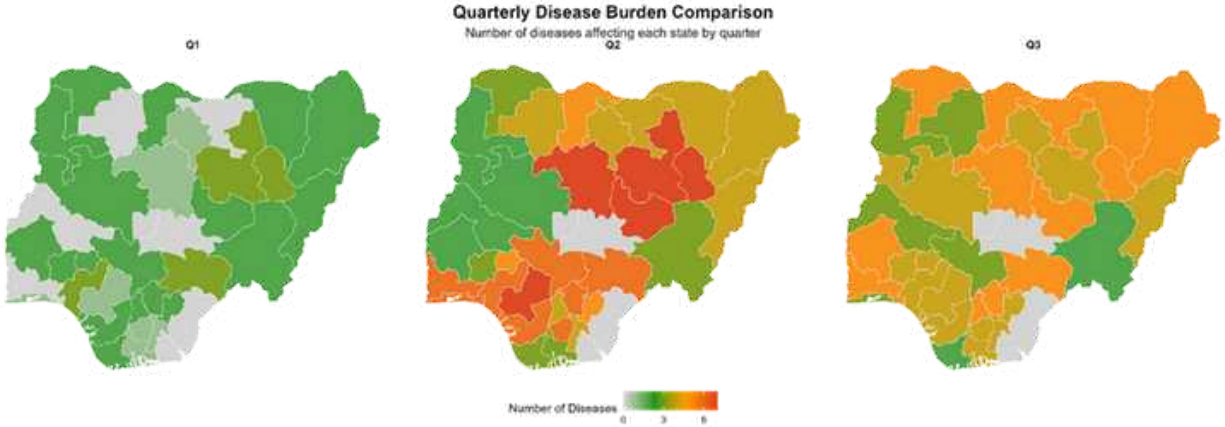


Figure 108: Suspected Diseases Burden Map, Q1-Q3

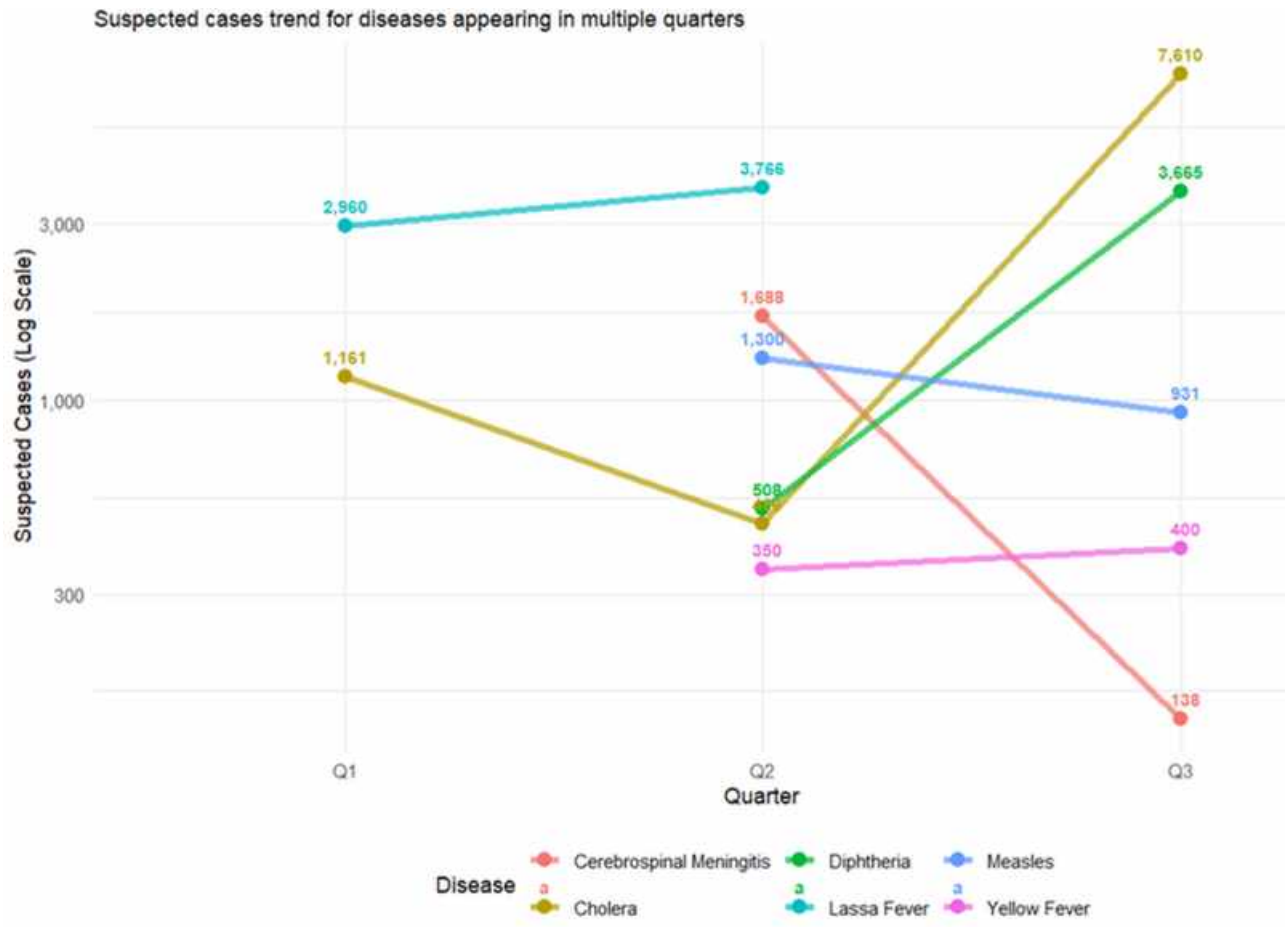


Figure 109: Suspected Cases Trend for diseases appearing in multiple quarters

The country experienced an increasing disease burden from January to September, with the highest suspected cases and mortality recorded in Q3 which was driven mainly by diphtheria and cholera. Laboratory confirmation rates improved, but outbreaks expanded geographically and several diseases persisted across quarters.

Geographic Hotspots

North-West Zone: Kebbi, Zamfara, Sokoto, Katsina - multiple concurrent outbreaks

North-Central Zone: Benue, Nasarawa, Plateau, Niger - heavy Lassa fever burden

Zamfara State: Experiencing triple burden (Cholera, Measles, and potentially others)

Antimicrobial Resistance (AMR)

Build climate resiliency for the health system

% of THFs that are part of national AMR surveillance network	(89%) 16 Teaching Hospitals and Federal Medical Centers
% of States with functional AMR governance structures	14%
% National AMR Surveillance Systemreporting rate	78%
% annual data submission rate to the WHO Global Antimicrobial Resistance and Use Surveillance System (GLASS)	100%
% of quarterly National AMR Technical Working Group (TWG) and AMR Coordinating Committee (AMRCC) meetings held	75%
% of tertiary hospitals that conducted the essential Antimicrobial Use Point Prevalence Survey (AMU PPS)	21%

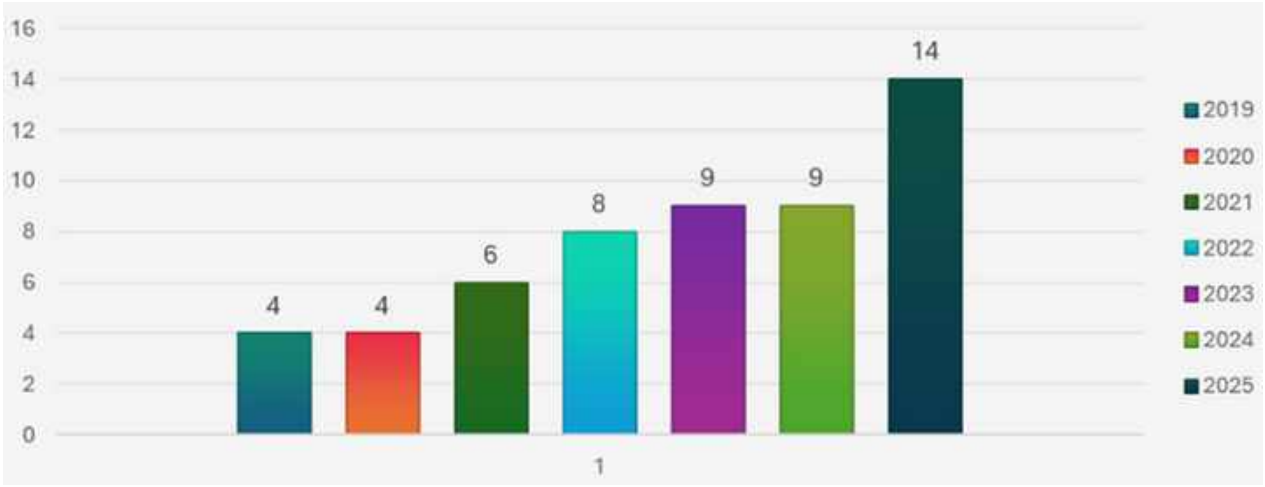


Figure 110: Annual Trend on Monthly AMR surveillance data submission (2019 - 2025) from sentinel sites

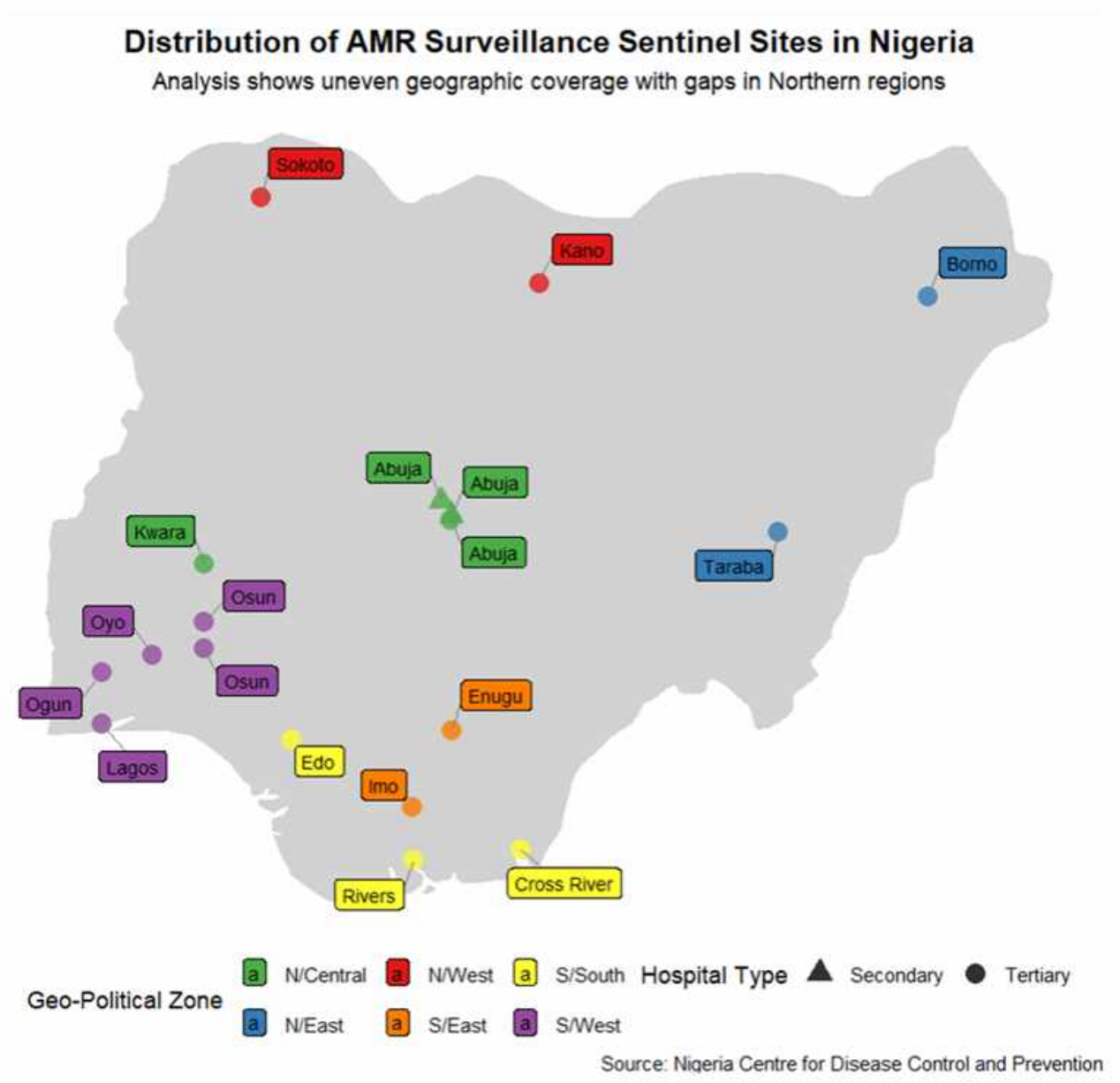


Figure 111: AMR Surveillance Sentinel Sites

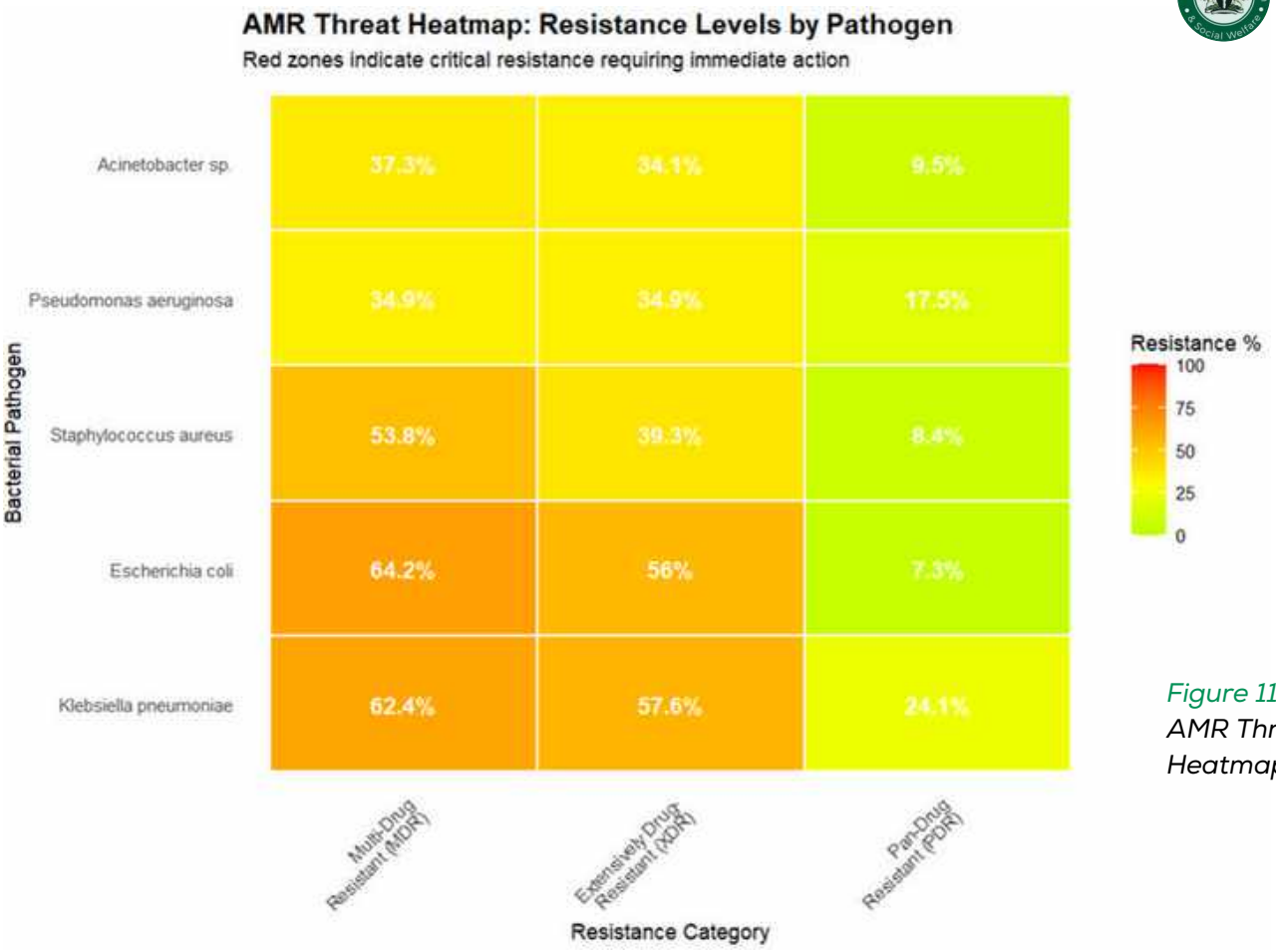


Figure 112: AMR Threat Heatmap

One Health

Number of national Joint Risk Assessments (JRAs) conducted	9	% of States with Joint Risk Assessment Capacity	19%	% of States with One Health committees	10%
% of States with One Health Strategic Plans	10%	Number of National One Health Technical Committee meetings held	2		

Build climate resiliency for the health system

Proportion of States implementing HNAP related green procurement strategies across health sectors	0	Proportion of States/FCT with integrated EWARS implemented for detection and response to climate linked health emergencies	0
% of States with integrated AMR surveillance sharing and producing yearly technical reports on trends, levels etc. for decision making	0	Numbers of health planners, architects, engineers, builders, and facility managers trained on low-carbon construction practices	0
Proportion of health facilities, EOCs and treatment centres that complied with the low-carbon building standards and protocol	0	Proportion of climate health resolutions implemented and tracked through a central accountability system	0

Key Achievements

In 2025, the health sector improved on the ability to detect and respond to health threats with more States strengthening the capacities of their PHEOCs, and increasing the number of IDSR Points using electronic platforms to report data timely. The year recorded less outbreaks compared to 2024 and previous years. Institutionalization of climate resilience in the health sector is in its nascent phase with few States adopting and implementing climate change strategies, low integration of such factors into treatment facilities, EOCs and other health institutions. Human capacity for climate change implementation is still weak at all levels, especially in the public sector.

The country made significant strides in combating Antimicrobial Resistance (AMR) through enhanced data-driven surveillance, system strengthening, and innovative public engagement. Digital AMR reporting increased by 71%, laboratory quality improved across 11 sites, and Whole Genome Sequencing was introduced for advanced surveillance. The country also demonstrated regional leadership by convening 15 West African nations on AMR coordination and launched the "SayAMR" Hackathon to boost community awareness through local language engagement.

Gaps and Bottlenecks

Bureaucratic bottlenecks hindering implementation in some states. Key challenges include recurrent disease outbreaks, an escalating antimicrobial resistance (AMR) crisis, and persistent gaps in funding and human resources that threaten the sustainability of recent gains.

Despite a strong national AMR framework and robust communication reach, the Risk Communication and Community Engagement (RCCE) faces major subnational challenges. Only 5.6% of states have adopted RCCE guidelines, and less than half of interventions are evidence-based,

limiting impact at the community level. Coordination gaps and institutional rivalries further hinder effective state and local implementation, highlighting the need to strengthen governance and data-driven approaches.

Recommendations

To strengthen health security, States should prioritize the expansion and full functionality of PHEOCs, supported by continuous capacity building for surveillance, data analysis, and rapid response teams. There is a critical need to accelerate the nationwide adoption of digital surveillance platforms such as e-IDSR to ensure real-time data reporting and integration across human, animal, and environmental health systems.

To improve efficiency, bureaucratic bottlenecks should be minimized through streamlined approval processes and dedicated budget lines for emergency response. Sustainable financing mechanisms, including contingency funds, should be institutionalized to enable rapid deployment of resources during outbreaks.

Efforts to combat Antimicrobial Resistance (AMR) should focus on strengthening governance and surveillance by establishing functional AMR committees in all States, expanding the network of sentinel laboratories, and promoting antimicrobial stewardship programs at both facility and community levels. The states should intensify efforts in implementing AMR intervention with the One health approach through the relevant ministries at the state level as an integrated intervention for corresponding minstires such as ministry of Environment and ministries of Agriculture and Livestock.

RCCE implementation should be improved through the domestication and operationalization of national guidelines in all States, with increased investment in community-led, evidence-based communication strategies that enhance trust and compliance.

Adoption of the One Health approach should be accelerated by expanding multisectoral coordination platforms, building risk assessment capacity, and developing a national implementation framework that links health, agriculture, and environment sectors.

Finally, climate resilience must be integrated into health sector planning through the development of low-carbon health infrastructure standards, the training of engineers and facility managers on sustainable construction practices, and the establishment of early warning systems for climate-related health threats.

06

Performance on the Three Enablers

Data and Digitalization

Digitize the health system & have data backed decision making

Financing

Increase the effectiveness of spending and alignment of spending with strategic priorities (on track)

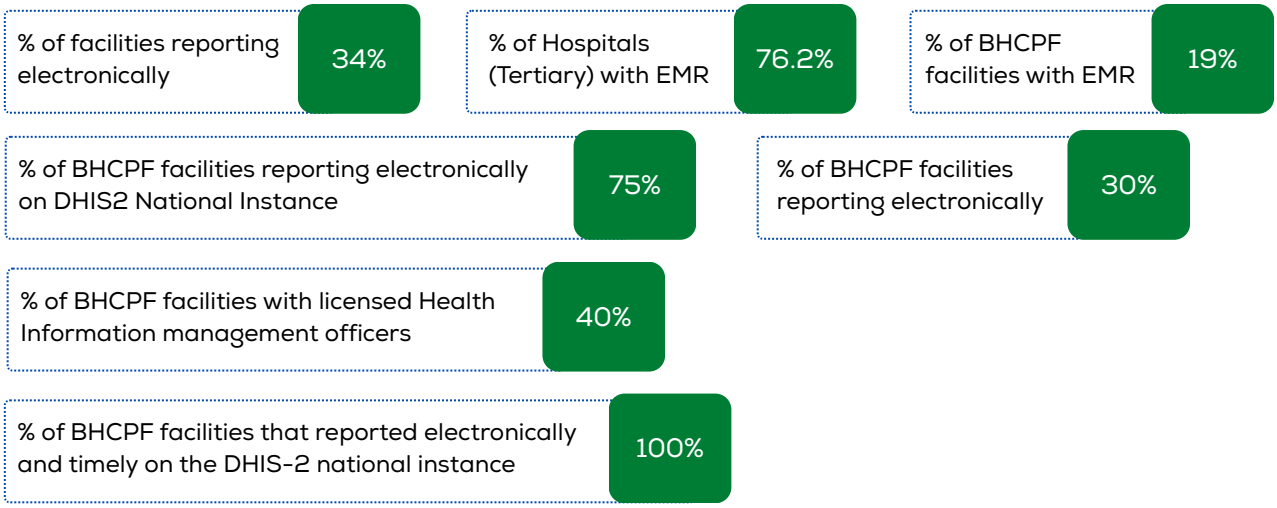
Culture and Talent within the MDAs

Strengthen skills, capabilities & values and drive a performance-based culture within the FMoH (on track)

National Health Management Information System (NHMIS)

The NHMIS as established by the National Health Act 2014 consists of health information from all sources (routine and periodic) that enable comprehensive decision-making at all levels of care and tiers of governance.

Routine Health Information Systems



States Health Information System

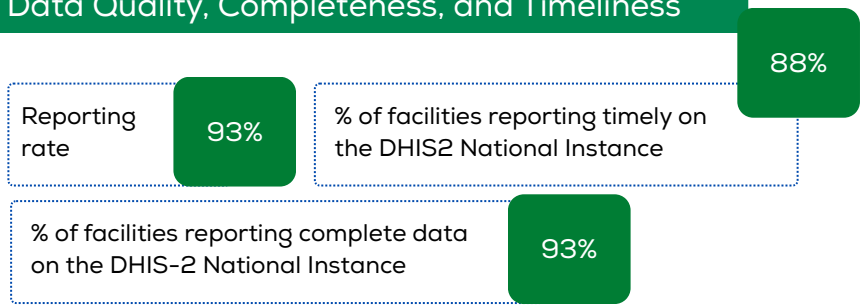
Most states did not report comprehensive data on the status of their health information systems. Majority either provided incomplete data or did not report all. While all Primary Health Care (PHC) facilities are largely reported electronically to DHIS2, the majority of Secondary Health Facilities (SHFs) and Tertiary Health Facilities (THFs) are still not reporting. Although some states have a considerable number of licensed Health Information Management officers, this has not been translated into full electronic reporting at SHF and THF levels.

Figure 113: Status of States Health Information System

State	Total # of facilities with licensed Health Information Management officers	Total # of PHCs reporting electronically to DHIS2	Total # of BHCPF facilities reporting electronically to DHIS2	Total # of SHCs reporting electronically to DHIS2	Total # of Teritary Health Facility reporting electronically to DHIS2	Total # of BHCPF Facilities in the State	Total # of BHCPF Facilities with EMR	Total # of PHCs with EMR	Total # of SHCs with EMR	Total # of Teritary Health Facility with EMR	Proportion of IDSR points using electronic platforms to report data timely
Abia		1,182	184		2	184	184	291			2
Adamawa	246	226									
Akwa Ibom	71	31									100
Anambra	12	0									0
Bauchi		938	212	24		212	0	0	0	1	
Bayelsa	44	299		72	2	102		18	3	2	2
Benue	3	276									
Borno	8.1	220									13379 ??
Cross River	289	1175									12
Delta	292	258									97
Ebonyi		1,983									100
Edo		497									
Ekiti		177									80
Enugu	0	990									100
FCT	65	-	0	5	0	62	0	4	61	6	38
Gombe	141	114	114	0	1	114	114	114	0	1	22
Imo	55	215									
Jigawa	275	256	256	0	0	281	0	0	0	1	100

Kaduna	290	253	254	0	0	255	255	254	0	1	82
Kano	458	484									85
Katsina	63	527	361	25	4	361	0	0	25	4	70
Kebbi	30	0									82
Kogi		220									100
Kwara	125	490									100
Lagos	2147	23	23	0	0	225	72	100	22	4	
Nasarawa	340	147	147	17	2	340	147	147	17	2	> 70
Niger		60%									
Ogun	105	236									4
Ondo		203	203	0	1	203	0	9	0	1	18
Osun	17					332					90
Oyo	635	764	351	50	4	351	0	0	0	4	
Plateau		0	207	0	0	207	34	34		2	45
Rivers (Reported only Q1 & Q2)		203									
Sokoto											
Taraba	68	168									100
Yobe	235	166	160	0	0	520	25	25	0	2	90
Zamfara		-									

Data Quality, Completeness, and Timeliness



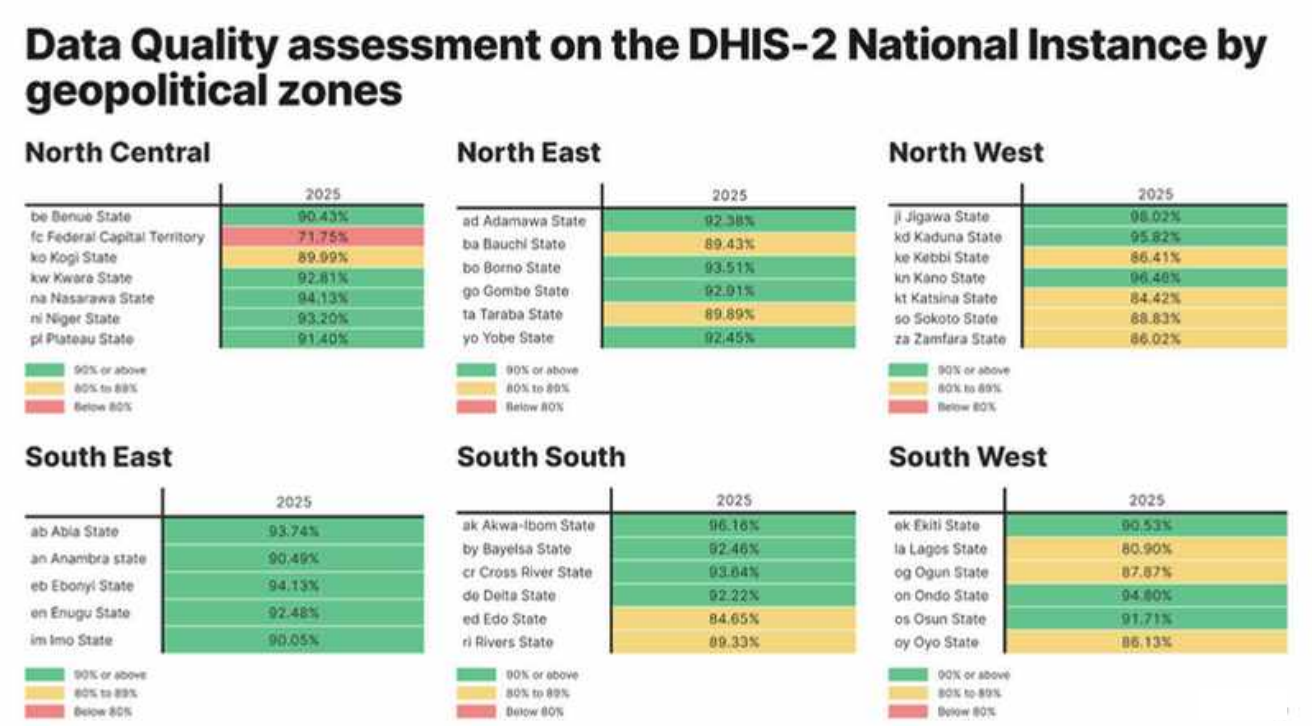


Figure 114: Data Quality Reporting for 2025 by zones

In 2025, data quality assessment on theDHIS-2 National Instance showed strong performance in the South East zone, where all states scored above 90%, indicating consistent and high standards when compared with other geopolitical zones in the country. The South West zone also demonstrated solid results, with most states above 90%, however, Lagos and Ogun fell slightly below 90% mark. North East zone maintained uniformity with all states above 89%.The North Central zone performed well overall but FCT recorded the lowest score (71.75%). The South South zone presented mixed outcomes, with Akwa-Ibom recording the highest score (96.16%) to Rivers recording the lowest (89.33%) in the zone. The North West zone had the greatest variation, with Jigawa and Kaduna exceeding 95%, while Kebbi and Katsina remained below 87% score, highlighting uneven data quality across the zone.

Table 11: Comparison of data quality by geopolitical zones

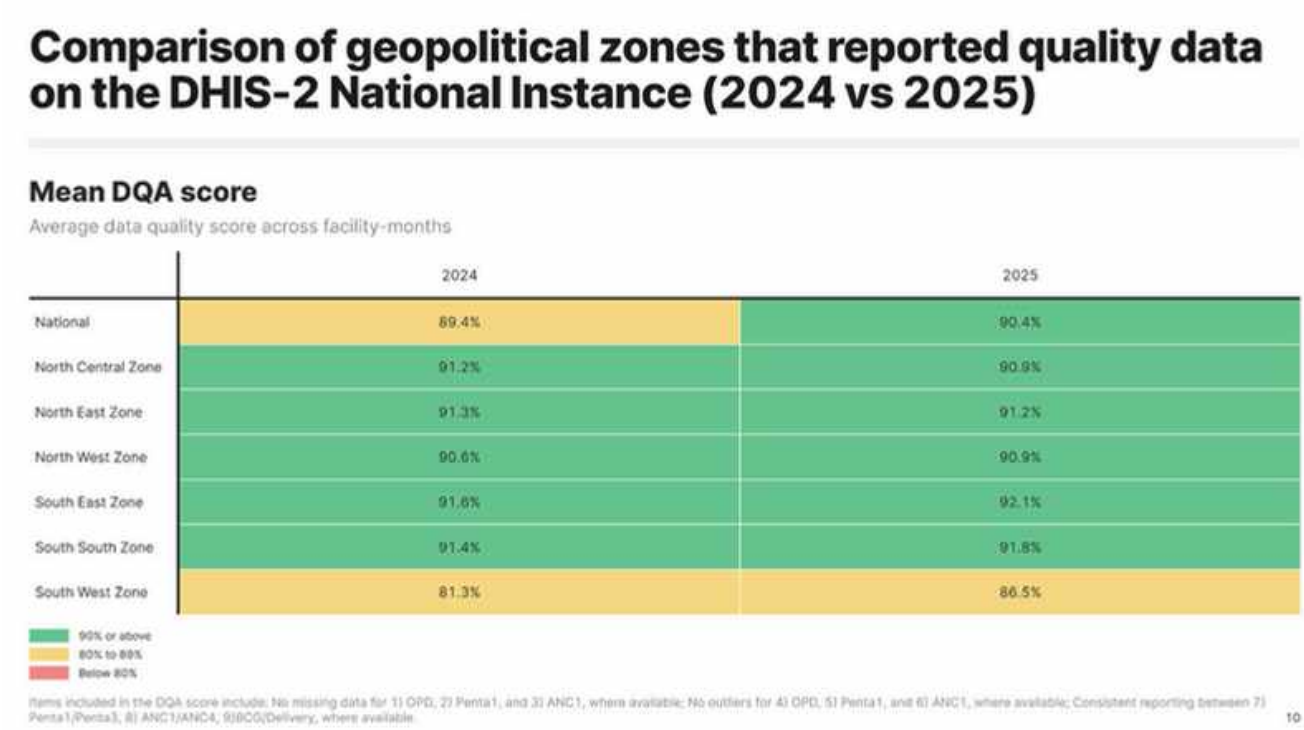
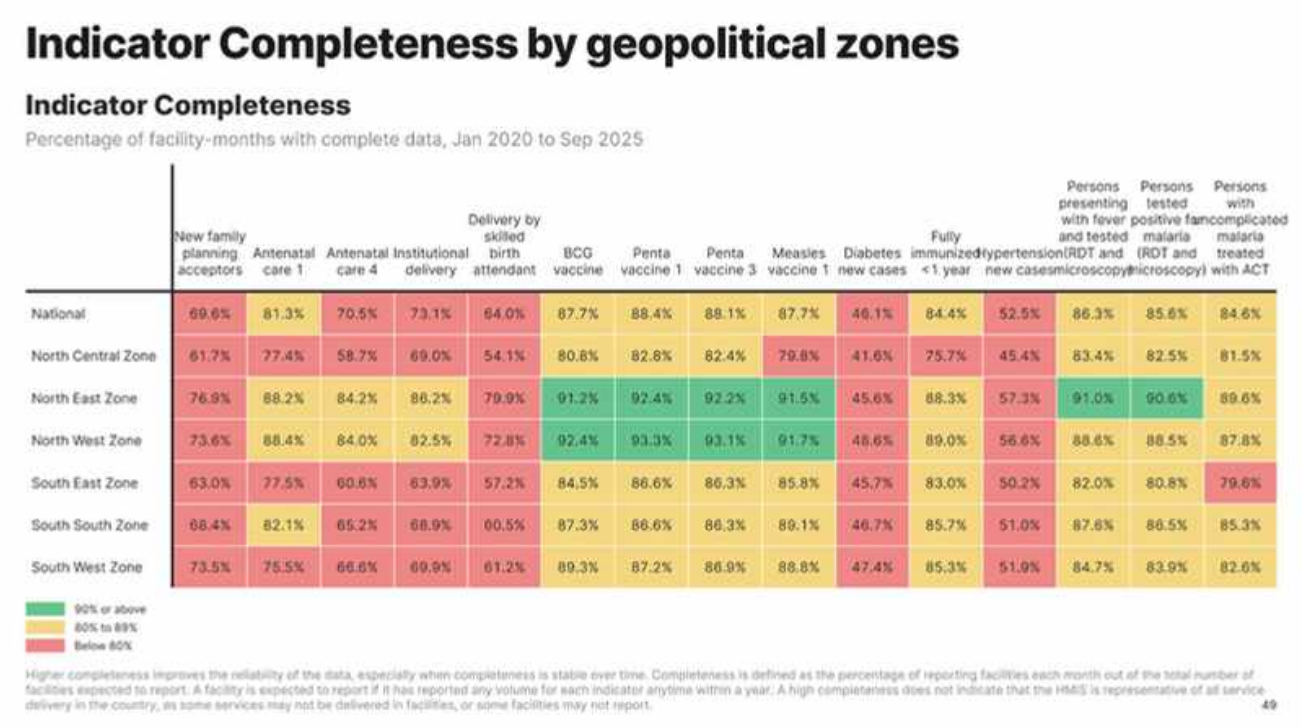


Table 11: Comparison of data quality by geopolitical zones

The table above shows the percentage of facilities in each zone that reported quality data on the DHIS-2 National Instance in the years 2024 and 2025. This comparison shows a slight overall improvement, with the national mean DQA score rising from 89.4% to 90.4%. Most zones maintained strong performance above 90%, including North Central (90.3%), North East (91.2%), North West (90.9%), South East (92.1%), and South South (91.8%). However, the South West zone, while improving from 81.3% to 86.5%, still lags behind other zones, indicating persistent gaps in data quality despite progress recorded.

Table 12: Key Performance Indicator Completeness by geopolitical zones



Indicator Completeness by geopolitical zones

Indicator Completeness

Percentage of facility-months with complete data, Jan 2020 to Sep 2025

	New family planning acceptors	Antenatal care 1	Antenatal care 4	Institutional delivery	Delivery by skilled birth attendant	BCG vaccine	Penta vaccine 1	Penta vaccine 3	Measles vaccine 1	Diabetes new cases	Fully immunized <1 year	Hypertension new cases	Persons presenting with fever and tested (RDT and microscopy)	Persons tested positive for malaria (RDT and microscopy)	Persons with uncomplicated malaria treated with ACT
National	69.6%	81.3%	70.5%	73.1%	64.0%	87.7%	88.4%	88.1%	87.7%	46.1%	84.4%	52.5%	86.3%	85.6%	84.6%
North Central Zone	61.7%	77.4%	58.7%	69.0%	54.1%	80.8%	82.8%	82.4%	79.8%	41.6%	75.7%	45.4%	83.4%	82.5%	81.5%
North East Zone	76.9%	88.2%	84.2%	86.2%	79.9%	91.2%	92.4%	92.2%	91.5%	45.6%	88.3%	57.3%	91.0%	90.6%	89.6%
North West Zone	73.6%	88.4%	84.0%	82.5%	72.8%	92.4%	93.3%	93.1%	91.7%	48.6%	89.0%	56.6%	88.6%	88.5%	87.8%
South East Zone	63.0%	77.5%	60.6%	63.9%	57.2%	84.5%	86.6%	86.3%	85.8%	45.7%	83.0%	50.2%	82.0%	80.8%	79.6%
South South Zone	68.4%	82.1%	65.2%	68.9%	60.5%	87.3%	88.6%	88.3%	89.1%	46.7%	85.7%	51.0%	87.8%	86.5%	85.3%
South West Zone	73.5%	75.5%	66.6%	69.9%	61.2%	89.3%	87.2%	86.9%	86.8%	47.4%	85.3%	51.9%	84.7%	83.9%	82.6%

90% or above
80% to 89%
Below 80%

Higher completeness improves the reliability of the data, especially when completeness is stable over time. Completeness is defined as the percentage of reporting facilities each month out of the total number of facilities expected to report. A facility is expected to report if it has reported any volume for each indicator anytime within a year. A high completeness does not indicate that the HMIS is representative of all service delivery in the country, as some services may not be delivered in facilities, or some facilities may not report.

49

After reviewing the Q1 to Q3 data for outliers, consistency, and completeness, the analysis above shows that missing data, stemming from incomplete reporting by many facilities, was the primary factor affecting data quality in 2025. Immunization indicators such as BCG and Penta vaccination coverage demonstrated relatively high completeness, often exceeding 85%, while maternal health indicators, including antenatal care and institutional delivery were consistently low, with most states reporting below 60%. Overall, child vaccination record have better and complete report compared to other maternal health and non-communicable disease indicators, underscoring the need for targeted interventions to improve completeness of reporting.

Interoperability of data systems	Weak fairly strong
% of routine data systems that meet FHIR standards	yet to be determined

To bridge the federal blueprint with state-level execution, a dedicated and robust governance network has been established. This includes the onboarding of 36+1 State Digital in Health Focal Persons (SDiHFPs) plus the FCT, forming a structured, nationwide body for coordination and adoption of digital standards across all states. This federated approach ensures that the National Digital Health Architecture is not just a federal directive but a coordinated national rollout. By securing political will, dedicated domestic funding, and an NCH policy mandate, Nigeria has established the three non-negotiable prerequisites for scalable digital transformation, creating an environment where the private HealthTech sector can innovate and develop solutions that are inherently interoperable and aligned with the national system.

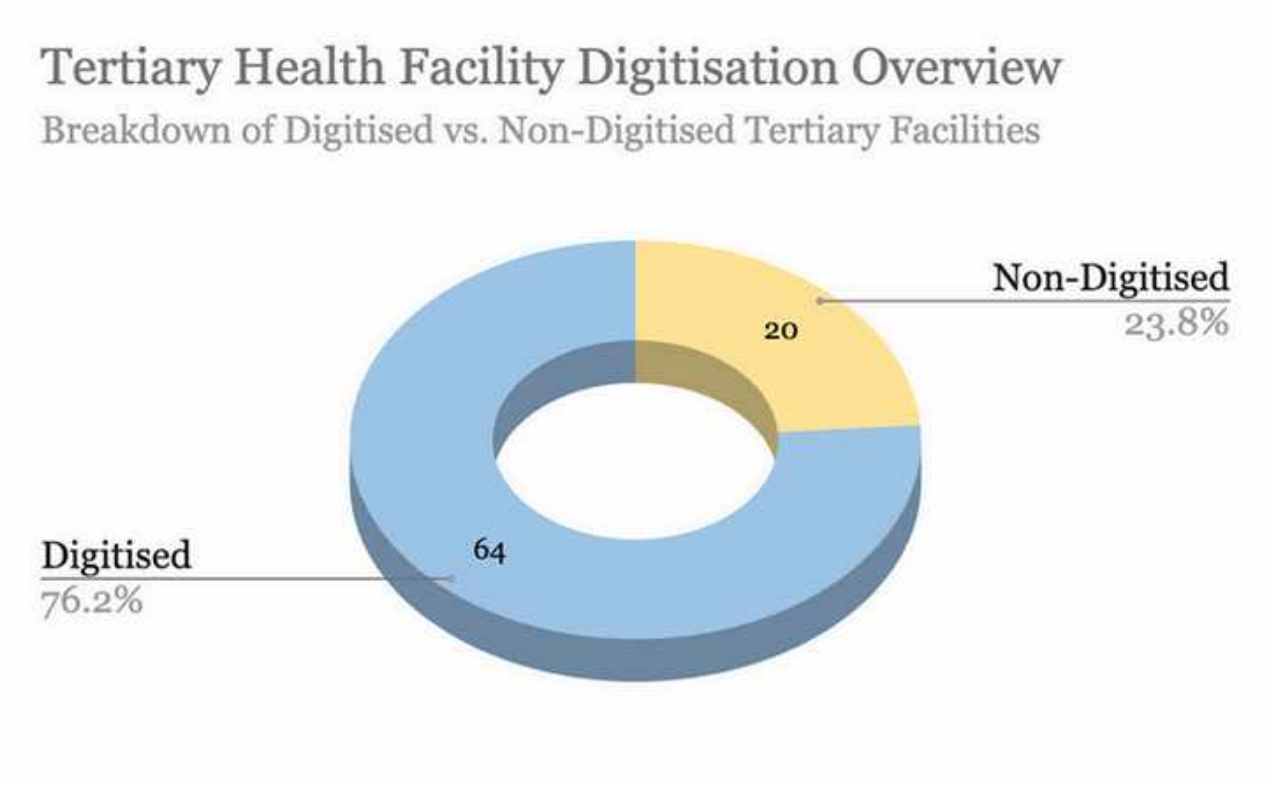


Figure 115: Overview of Tertiary Health Facility Digitization

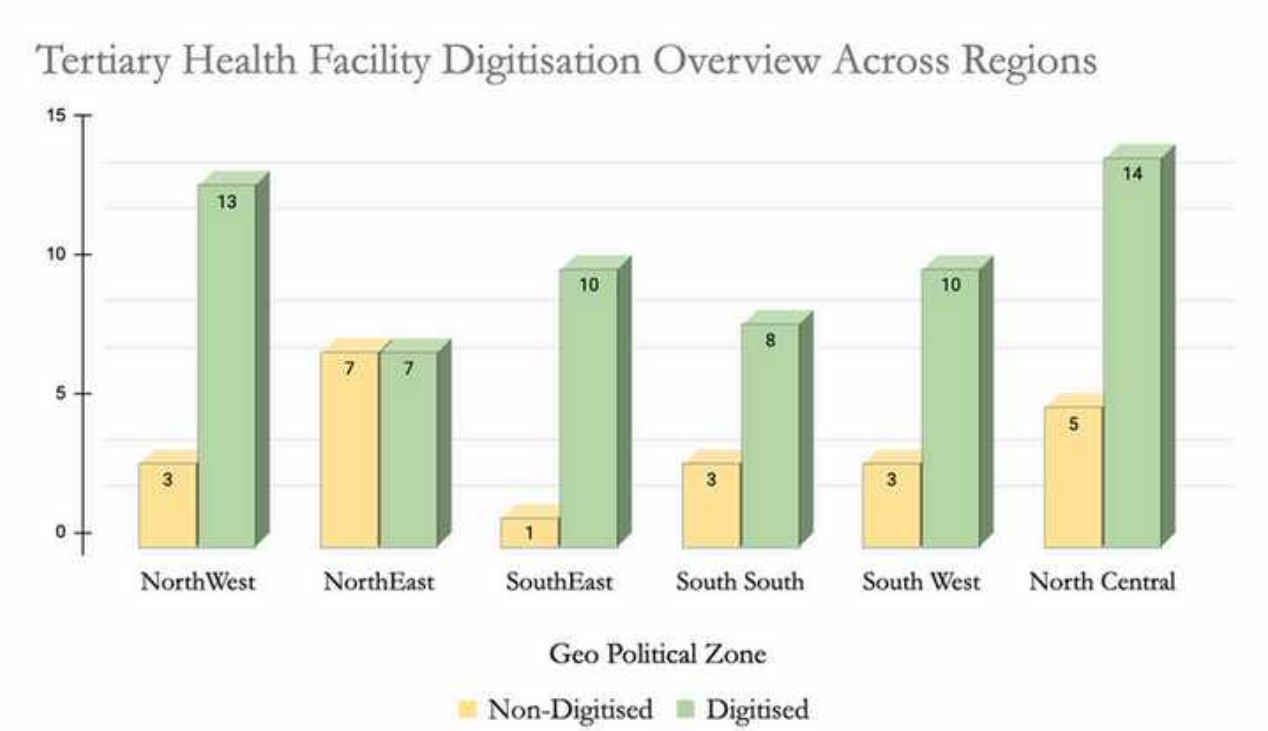
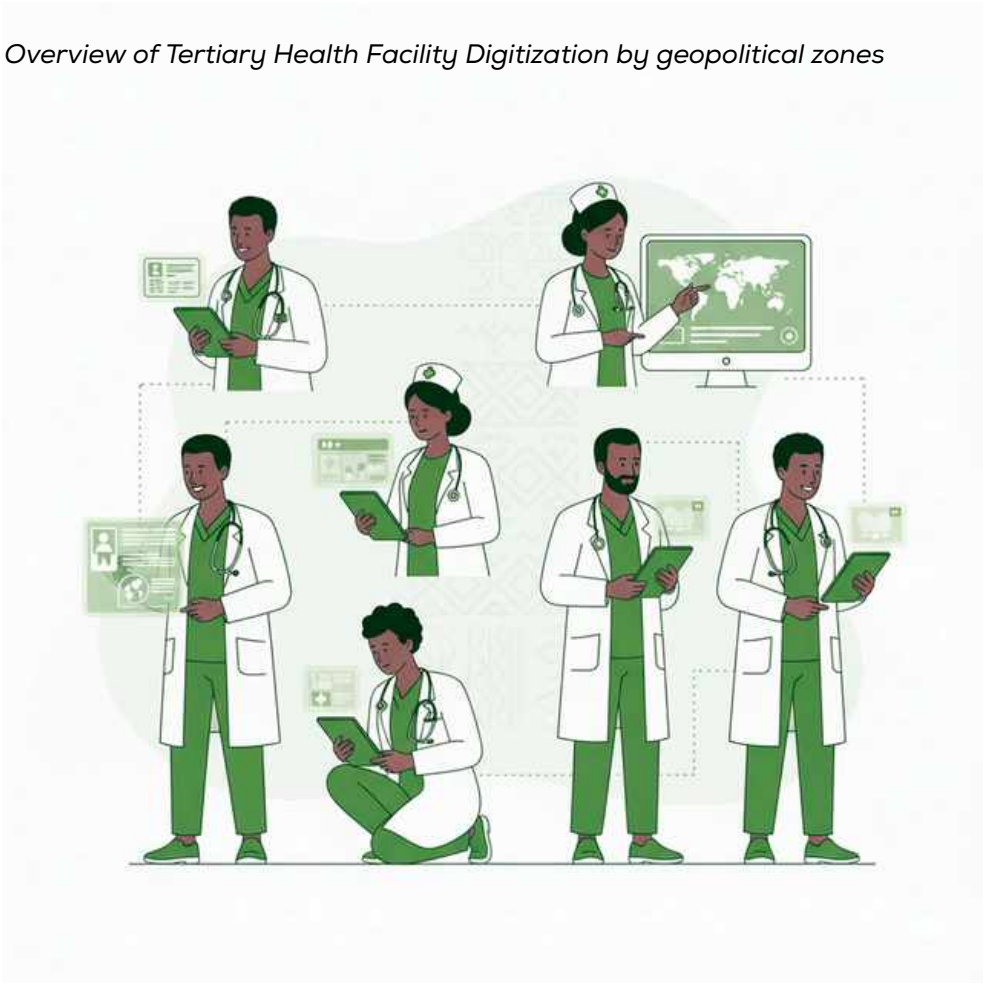


Figure 116: Overview of Tertiary Health Facility Digitization by geopolitical zones



Availability of research priorities	yes	Number of Health Research Proposals/protocols reviewed and approved by NHREC	5

To bridge the federal blueprint with state-level execution, a dedicated and robust governance network has been established. This includes the onboarding of 36+1 State Digital in Health Focal Persons (SDiHFPs) plus the FCT, forming a structured, nationwide body for coordination and adoption of digital standards across all states. This federated approach ensures that the National Digital Health Architecture is not just a federal directive but a coordinated national rollout. By securing political will, dedicated domestic funding, and an NCH policy mandate, Nigeria has established the three non-negotiable prerequisites for scalable digital transformation, creating an environment where the private HealthTech sector can innovate and develop solutions that are inherently interoperable and aligned with the national system.

Achievements

The deployment of over 6000 laptops and the redeployment of HIM officers to BHCPF facilities have resulted in timely data reporting on the DHIS-2 National Instance. The deployment of tablets to BHCPF facilities enabled the provision of quality services through EMR, and the transmission of real-time quality data. Another key milestone recorded in the period under review is the ongoing linkage of routine data systems with CRVS and NIMC to improve patient and client registration and identification.

Regarding the periodic information system assessment, quarterly performance review such as presidential report, quarterly review, data quality assessments, joint facility spot checks, facility assessments for standards etc. were institutionalized and conducted in the period under review.

Population surveys are also being strengthened through digitization of data collection tools and processes, definition and standardization of survey indicators, and alignment with the administrative data system. The development of in-country capacity for the conduct of surveys and assessments, especially regarding survey design and data collection processes, has significantly improved in the year under review.

The Federal Ministry of Health and Social Welfare (FMOHSW) conducted comprehensive assessments of Electronic Medical Record (EMR) systems across federal tertiary health institutions (FTHIs) to evaluate their current status. These assessments focused on infrastructure, technical capabilities, human resources, power supply, legal compliance, and process flows. The objective was to identify gaps in systems functionality, interoperability, and alignment with national standards like FHIR and SNOMED CT. The findings provided critical insights into challenges such as data silos and inconsistent reporting, informing strategies for upgrading EMR systems and supporting the development of a unified national health data architecture to enhance care delivery and decision-making. Standards have been established for data and digital systems (FHIR) across the country, and the institutionalization of these set of standards will commence from 2026.

Similarly, in 2025, Nigeria started the process of standardizing health survey indicators and the alignment with administrative data systems towards ensuring actualization of a single source of truth.

There was a significant improvement in data use for decision making at all levels as evidenced by the growing volume of health data for quarterly reviews and dialogues. Majority of states (90%) conducted state-level JAR and implemented feedback mechanisms. The need for quality data is currently being mitigated by the implementation of the FASTR initiative led by the Federal Ministry of Health & Social Welfare to adjust routine data for decision-making and program planning.

Gaps

Key gaps in the NHMIS include proliferation of fragmented data systems with little or no interoperability standards. Incomplete data reporting remains a challenge across most states in the country. Weak linkage of EMRs platform with the national systems such as the DHIS-2 National Instance, LMIS, SORMAS etc. remains a key challenge. Similarly, community data systems are weak and remain fragmented.

Recommendations

Undertake fitness and compliance assessments of all routine data systems including the community health information system. Establish a Health Information Exchange to foster interoperability and integration. Improve funding including innovative funding approaches for health system research.

Enabler II: Health Financing

Increase the effectiveness of spending and alignment with strategic priorities

Budget Allocation vs. Execution (Federal, State & Partners)

Routine Health Information Systems

Total federal budget allocation	₦2.48 trillion	Total states budget allocations	₦1.86 Trillion
Total amount pooled by SWAp office	$1.18 Billion*	Total amount raised by PVAC	XX Billion
Total contribution by Partners	$1.34 Billion	Funding for R&D for essential medicines & vaccines	xx

*Current Multi- Donor Trust Fund (MTDF) Funders Total amount = $1,180,000,000. Inclusive of $10,670,000 from CIFF yet to be remitted.

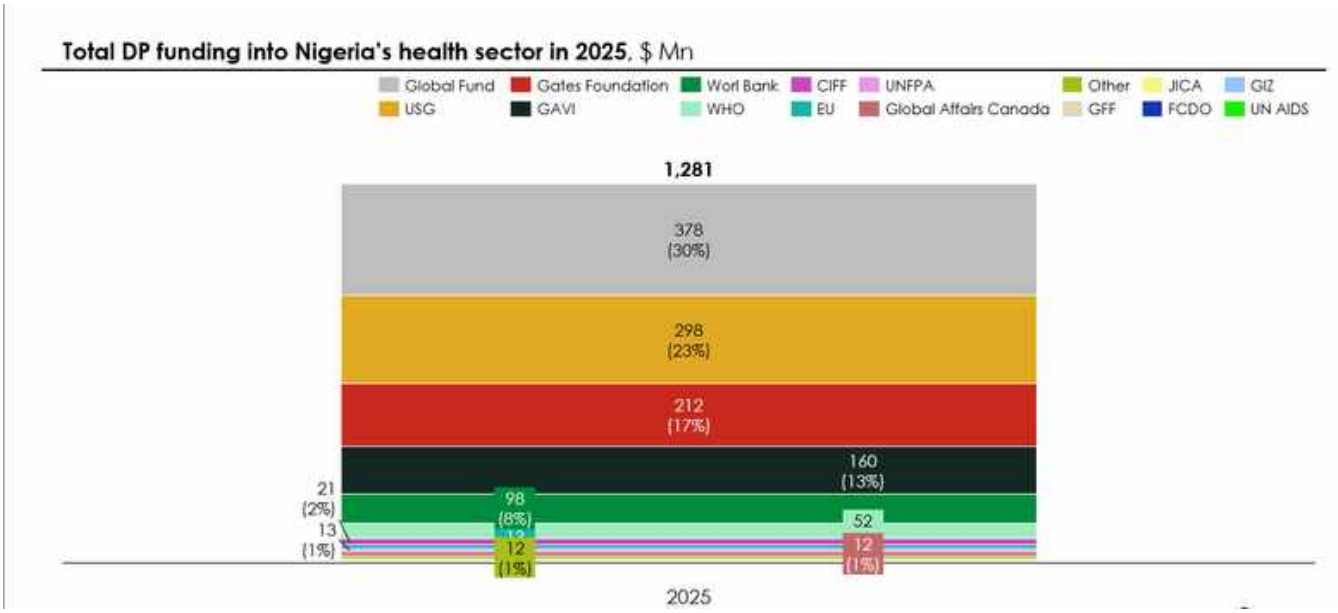


Figure 117: 2025 Development Partner budget forecasts (in USD' millions) (Source: RMET 2025-2027 report)

The above figure shows the 2025 health sector funding from development partners and reveal 83% of the allocations in 2025 are from four development partners namely; Global Fund ($378M – 30%), USG ($298M – 23%), Gates Foundation ($212M – 17%) and GAVI ($160M – 13%).

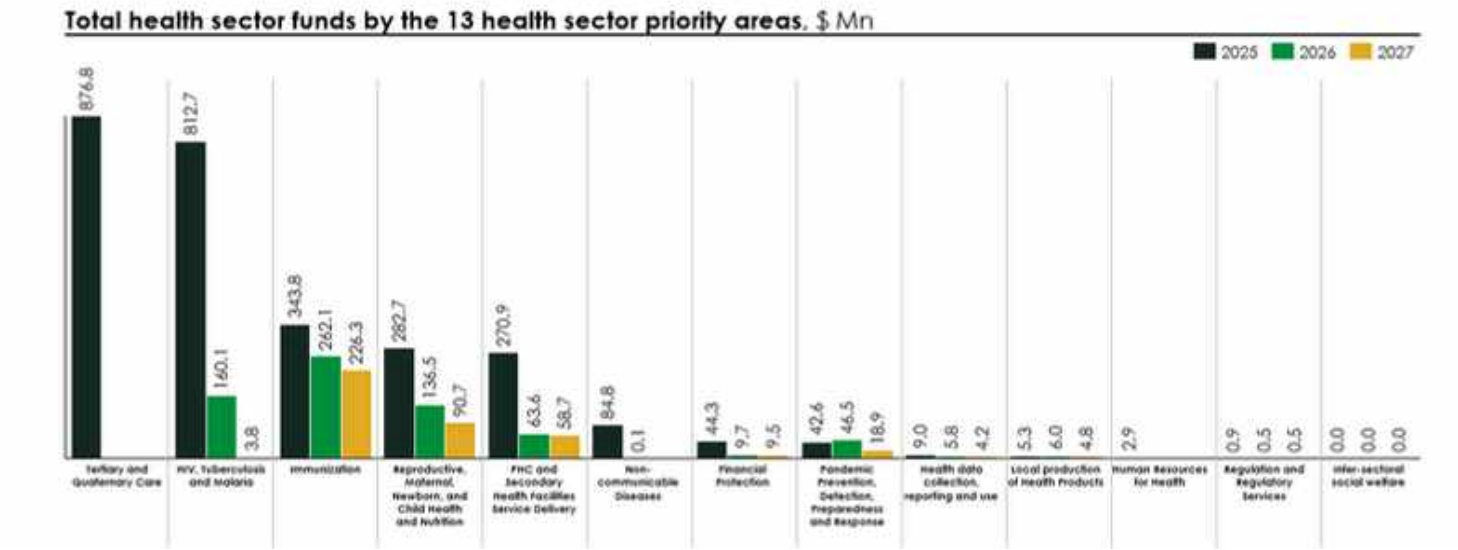


Figure 118: Federal Government Appropriation and Partner Commitments (in USD' millions) by health sector priority areas (Source: RMET 2025-2027 report)

The figure shows the 2025–2027 Federal Government appropriation and donor commitments by program function, showing that the highest allocations in 2025 are directed toward Tertiary and quaternary care ($876.8M), HIV/TB/Malaria ($812.7M), Immunization ($343.8M) and SRMNCH ($282.7M). Funding generally declines year on year across most programs over the three-year period, with notable drops in areas like HIV/AIDS and SRMNCH. This drop is partly related to unavailability of post-2025 finance data from some Partners as at the time of compilation of this report.

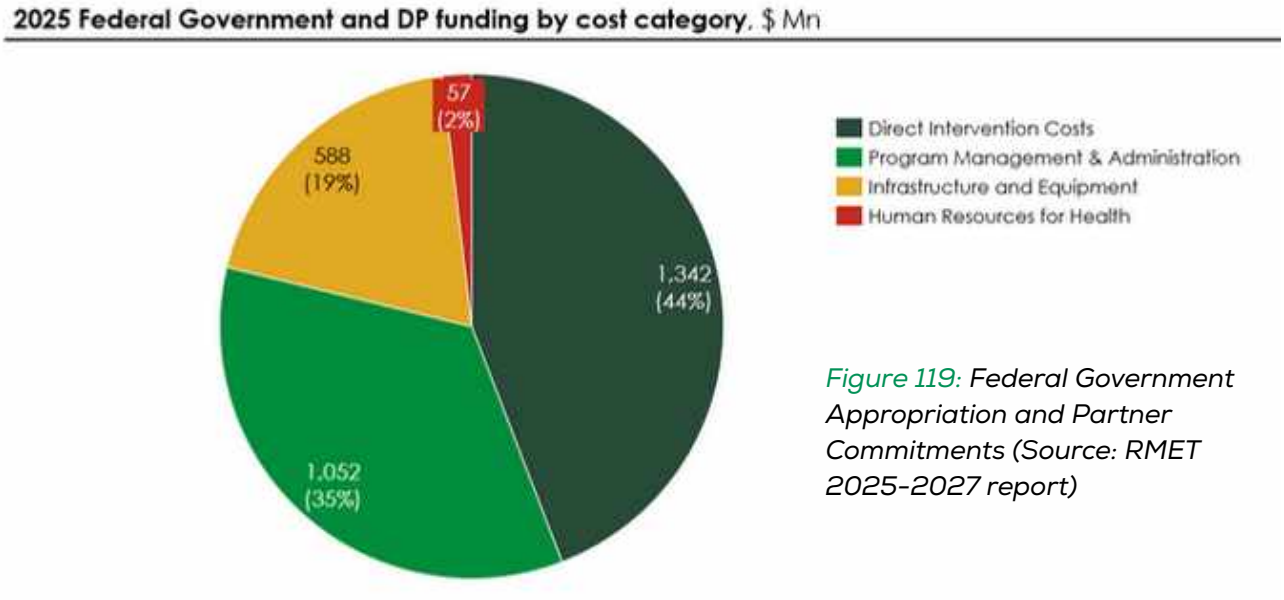


Figure 119: Federal Government Appropriation and Partner Commitments (Source: RMET 2025-2027 report)

The 2025 resource map allocates the largest share to Direct Interventions, accounting for $1,342 million (44%) of the total forecast. Program Management and Administration follows with $1,052 million (35%), while Infrastructure and Equipment receives $588 million (19%). Human Resources for Health represents the smallest proportion, at $57 million (2%). This distribution highlights the prioritization of direct service delivery and administrative management in the 2025 budget.

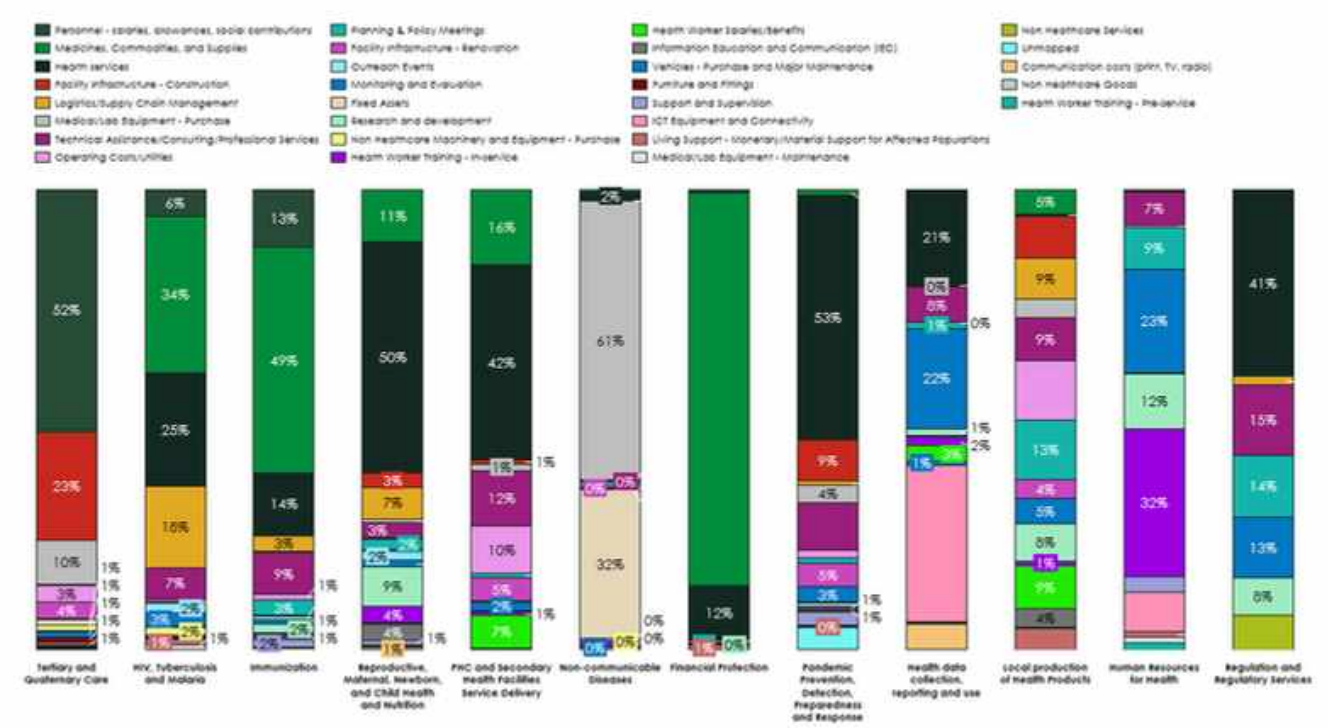


Figure 120: 2025 FG and DP health sector budget forecasts segregated by key cost drivers across programs (Source: RMET 2025-2027 report)

The chart illustrates total health funds and its allocations (federal government and donors) across the health sector priority areas for 2025, highlighting variations in priorities. Most funds for Tertiary and Quaternary Care are directed toward personnel cost, while HIV/AIDS, TB and Malaria, Immunization, Reproductive, Maternal, Newborn, and Child Health and Nutrition programs are focused on medicines, commodities and supplies, health services and logistics/supply chain management. Primary Health Care and Secondary Health Facilities, Service Delivery, Malaria, Immunization and Pandemic Prevention, Detection, Preparedness and Response, show great diversification including operational cost, salaries and infrastructure. Overall, the distribution reflects program-specific investment patterns aligned with service delivery needs.

The 2025 health sector budget (federal government and donors), broken down by key cost drivers across programs, indicates that the majority of funds are directed toward health services, procurement of medicines and commodities, and technical assistance, as illustrated in Table 13 below.

Table 13: Breakdown of Cost Drivers (Source: RMET 2025-2027 report)

Cost Category	Cost Drivers	2025 (USD $)	(2025 /%)
Program Management & Administration	Includes monitoring and evaluation, personnel costs such as salaries, allowances, and social contributions, operating costs/utilities, planning & policy meetings, communication, technical assistance /consulting / professional services and support and supervision costs	**$1,052,297,719**	**34.60%**
Human Resources for Health	Includes health worker salaries/benefits, health worker training (both in-service and pre-service),	**$56,563,551**	**1.90%**
Infrastructure & Equipment	Includes facility infrastructure costs for renovation and construction, ICT equipment and connectivity expenses, and medical/lab equipment costs for both purchase and maintenance	$588,043,157	**19.40%**
Direct Interventions	Includes outreach events, healthcare services, living support such as monetary/material support for affected populations, logistics/supply chain management, medicines, commodities, and supplies	**$1,341,559,288**	**44.20%**

Of the approximately USD $3.04 million allocated across cost elements in 2025, approximately 34% was directed toward program management and administrative costs, while about 44% was to direct interventions.

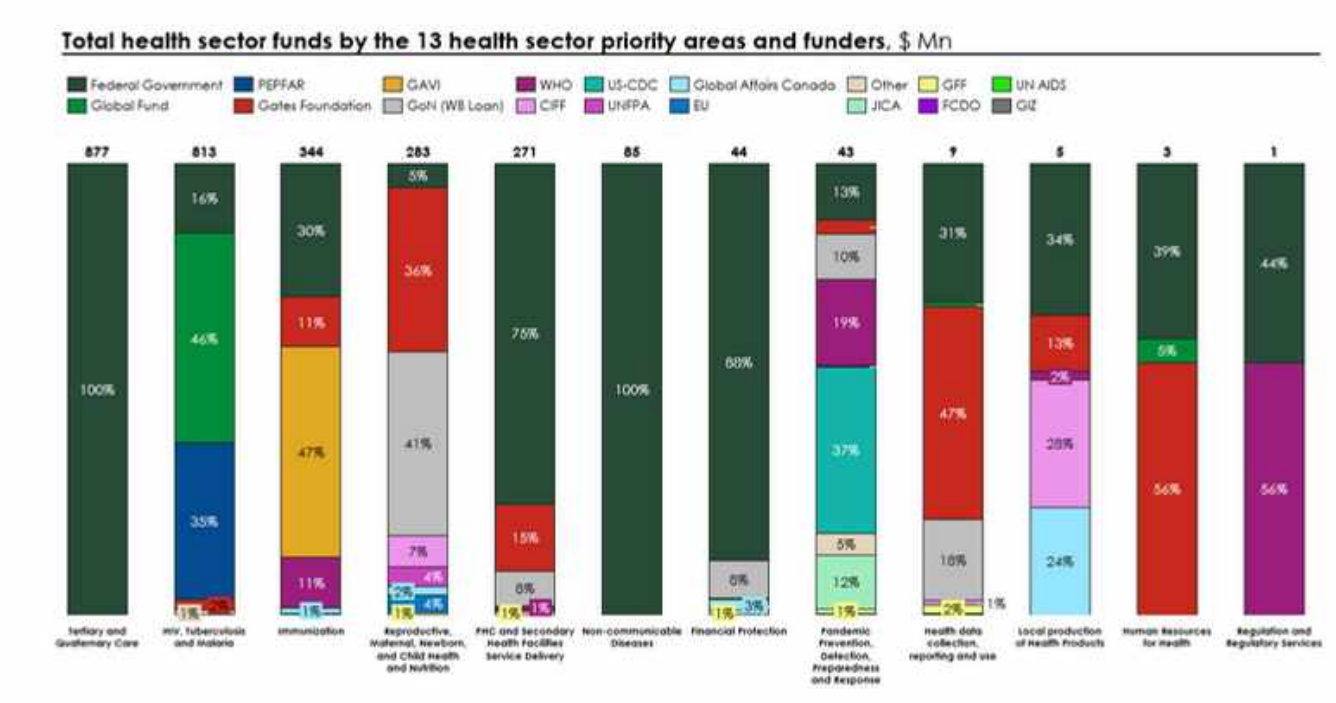


Figure 121: 2025 FG appropriation and DP commitments by 13 priority areas (USD' millions) & Funder (% Contribution) (Source: RMET 2025-2027 report).

The above figure shows FG and DPs' mapped resources by program function in USD millions, along with the percentage contributions of various funders for each health program area. It highlights significant funding variations, with Tertiary and Quaternary Care receiving the highest allocation ($877M) from the FG (100%), followed closely by HIV, Tuberculosis and Malaria ($813M) mainly funded by Global fund (46%) and PEPFAR (35%) while Human Resources for Health and Regulation and Regulatory Services receive the least ($3M and $1M respectively), funded primarily by Federal Government, Gates Foundation and WHO.

Basic Health Care Provision Fund (BHCPF) Performance

Total BHCPF budget allocation (2025)	₦402 billion	Total Partner contributions to the BHCPF (2025)	0
Total Private sector contributions to the BHCPF	xxxx	Total BHCPF disbursements	₦32.9B(Q1&Q2)

Percentage of donors fulfilling their funding commitments to BHCPF implementation (disaggregated by type – donors and private sector)	100%
Number of facilities where NHIA and NPHCDA payment gateways converge	xx
Number of facilities receiving only capitation from NHIA gateway.	xx
No of facilities receiving only direct facility financing from NPHCDA gateway.	

Health Insurance Coverage

Health Insurance Coverage and Utilization

Total population covered by any form of approved health insurance	21.1million	Population (vulnerable group) covered through the BHCPF	2.4million
Number of Indigent Nigerians Covered by the VGF and Other SAF	6.6million	Rate of utilization of any form of approved health insurance (and the B)	16.5%
% of household out of pocket spending as proportion of Current Health Expenditure	71.7%		

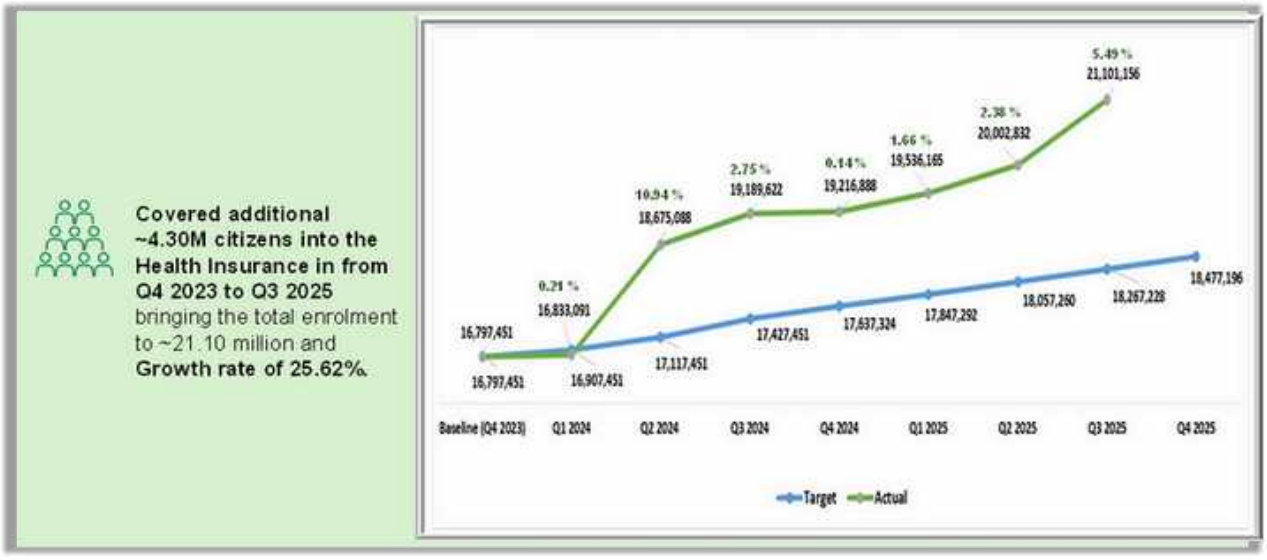


Figure 122: Health Insurance Coverage (Target vs Achievement)

Achievements

Nigeria recorded notable progress in health financing in 2025, with over ₦4.3 trillion allocated by federal and state governments and $1.34 billion contributed by development partners. More than 21.1 million Nigerians are now covered by health insurance, including 6.6 million vulnerable individuals. Improved budgeting under the RMET 2025–2027 framework, enhanced alignment of government and partner funding, and stronger coordination between the NHIA and NPHCDA have increased transparency, efficiency, and progress toward Universal Health Coverage (UHC).

The sector also demonstrated resilience by absorbing the impact of the funding cuts from the United States Government, maintaining stability through increased support from other external donors and expanded domestic financing.

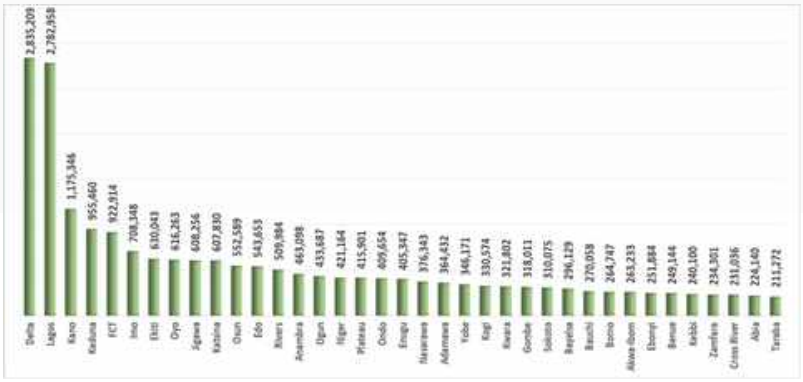


Figure 123: Health insurance coverage across the state highlighting Top performing States

Gaps

Despite these gains, inefficiencies in fund utilization and inequities in resource allocation persist. Budget execution remains sub-optimal, with 34% of resources directed to administrative costs and limited funds reaching front-line service delivery. Funding continues to be skewed toward tertiary care, while investments in primary health care and the health workforce remain inadequate. Private sector participation in the BHCPF is weak, and out-of-pocket expenditure remains high at 71.7%, exposing households to financial risk. Fragmented pooling systems, declining donor funding, limited research investment, and slow adoption of local production capacity further constrain sustainability. Delays in releasing budgetary allocations at both national and sub-national levels also hinder program implementation. Despite growing enrolment, only about 10% of the population currently has health insurance coverage, and public awareness of health insurance remains low.

Recommendations

To strengthen financing efficiency and equity, Nigeria should enhance fiscal accountability, adopt performance-based financing, and prioritize funding for primary health care, preventive services, and human resource development. Expanding private sector engagement and fully enforcing mandatory health insurance will improve risk pooling and reduce out-of-pocket spending. The integration of NHIA–NPHCDA payment gateways, establishment of a Health Research and Innovation Fund, and development of a donor transition plan will enhance coordination and sustainability. Government should also strengthen domestic resource mobilization, ensure timely release of health funds through robust accountability mechanisms, expand public awareness on health insurance, and invest strategically in essential health infrastructure to advance progress toward Universal Health Coverage.

Enabler III: Culture and Talent Management

Strengthen skills, capabilities & values and drive a performance-based culture within the FmoH

Improve FMOHSW Staff Skills & Capabilities

% of FMoHSW staff trained on Performance Management System	80%

Drive Performance-Based Culture

% of Ministry of Health (MoH) staff with satisfactory performance rating in the Ministerial Performance Management System (PMS)	82%
Number of staff with improved performance metrics	1,850 (Target: 2,252 staff)
% of Health DAPs trained on Performance Monitoring System	57%

Achievements

The institutionalization of the Performance Management System (PMS) where roles are assigned to officers to ensure responsible persons are held accountable in case of service gaps across DAPs has reduced the import of redundancy in the health sector. The introduction of Enterprise Content Management (ECM) in well over 50% of the DAPs had led to an improved employee commitment/performance, enhanced transparency and increased productivity and had also reduced the incident of missing/misplacement of files/documents. Again, the digitalization of the payment platform for the processing of yellow cards has reduced the incident of corruption from scrupulous elements and also the reduction of the waiting time for yellow cards from 25 minutes to 15 minutes. In overall rating, the introduction of new initiatives had led to an improved service delivery.

Gaps

Planned upskilling of staff of FMOHSW staff and other health workers across the sector have been hampered non-budgetary release of funds, and funding cuts even among donor partners.

Recommendations

Innovative financing mechanisms should be put in place to ensure sustainable capacity building for health sector workers at Federal State and LGA levels.

Key Interventions

MAMII 1

Maternal and Neonatal Mortality Reduction Innovation Initiative The MAMII intervention is an initiative launched in November 2024, designed to crash maternal and newborn deaths by 30% and 20% respectively in 172 high burden Local Government Areas (LGAs) across the country. Since commencement, factors critical to mortality in the selected LGAs have been identified and bespoke measures are being taken to address the challenges. MAMII deploys a comprehensive suite of context-specific targeted interventions geared toward strengthening governance and accountability systems, generating demand at community level, improving access to and quality of skilled services, strengthening financing and performance management systems, amongst others

Total Number of the Facilities revitalised In 172 LGAs	435
ANC first Booking before 20 weeks in 172 LGAs	729,724
ANC 4th Visit in 172 LGAs	794,205
Total Deliveries (Q1-Q3 2025)	731,559
Still Births (Q1-Q3 2025)	21,172
Total Maternal Deaths (Q1-Q3 2025)	841
Total Neonatal Deaths (Q1-Q3 2025)	1245
Percentage of 172 LGAs with at least two L2 Facilities	52%
Percentage of 172 LGAs with 1 PHC per ward (BHCPF facilities)	78%
% reduction in maternal deaths in identified 172 LGAs	17%
% reduction in newborn death in identified 172 LGAs	12%
Percentage of BHCPF facilities in 172 LGAs linked to SEMSAS/NEMSAS	25%
Number of referrals in 172 LGAs completed on the NEMSAS system	7451
Percentage of BHCPF facilities in 172 LGAs with at least 2 midwives	12%
Percentage of LGAs equipped with heat stable carbetocin in 172 LGAs	47%
Percentage of BHCPF facilities in 172 LGAs with at least 1 laboratory technician	20%
Total number of women in 172 LGAs line listed	411,296

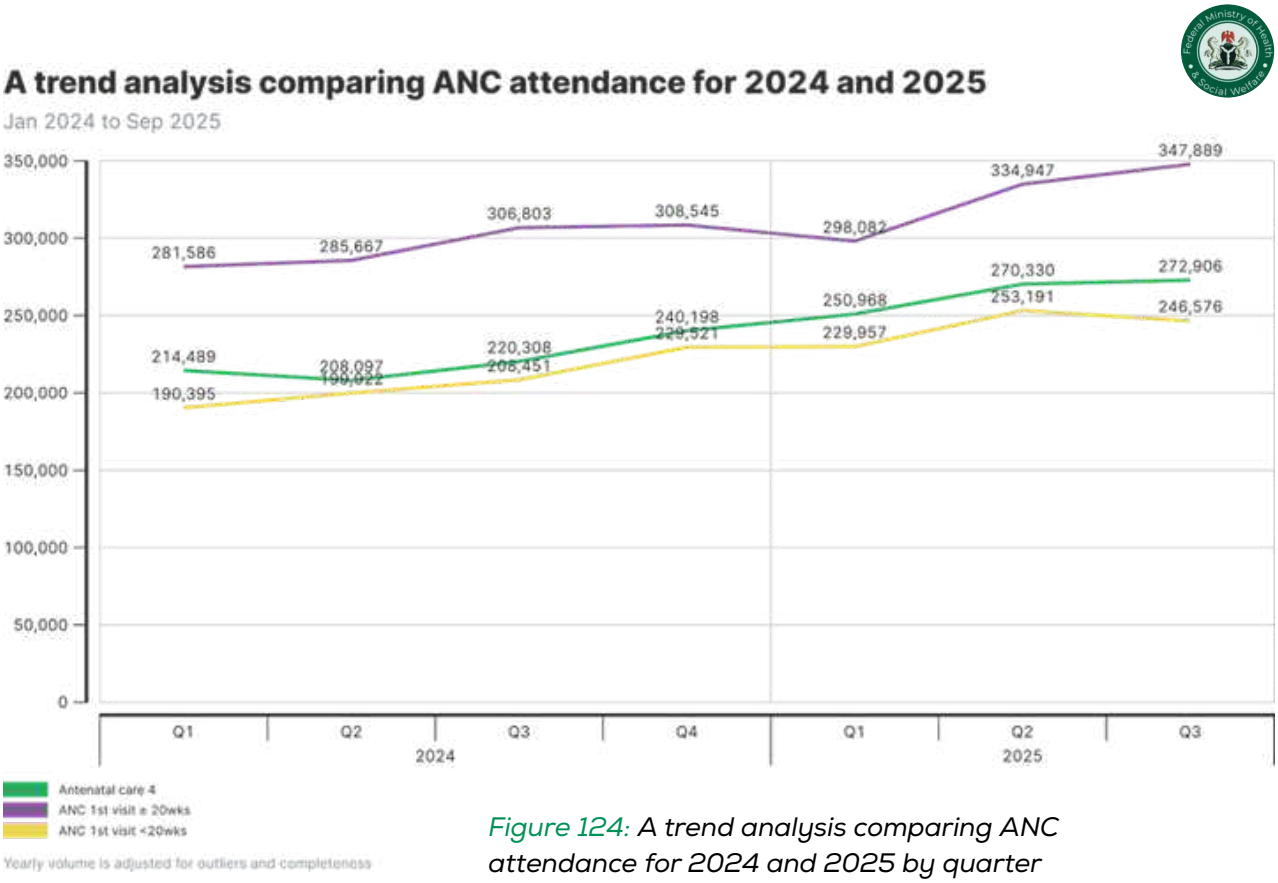


Figure 124: A trend analysis comparing ANC attendance for 2024 and 2025 by quarter

Figure 124 comparing ANC attendance for 2024 and 2025 highlights a steady increase across the three ANC-themed indicators in 2025. Improved ANC attendance, complemented by health promotion and demand generation, including birth preparedness planning significantly reduces the risk of maternal and newborn deaths.

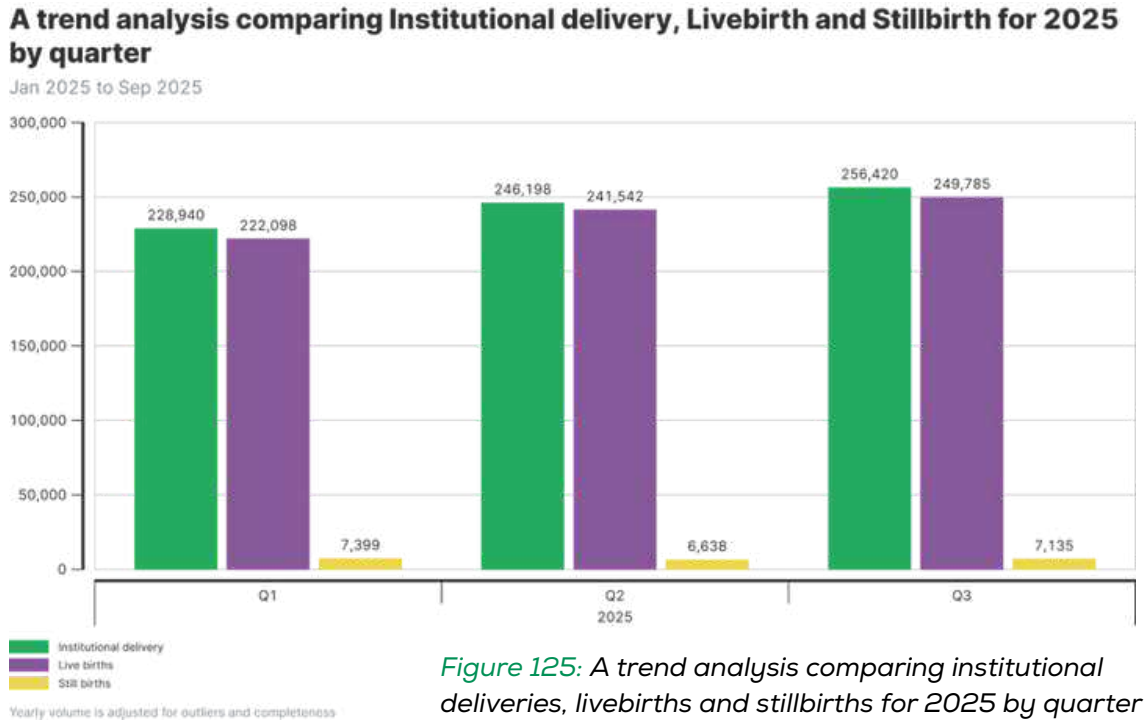


Figure 125: A trend analysis comparing institutional deliveries, livebirths and stillbirths for 2025 by quarter

Figure 125 presents a quarterly trend analysis for 2025, comparing the number of institutional deliveries, live births, and stillbirths across health facilities in the MAMII LGAs. The data shows a generally consistent pattern between institutional deliveries and live births, indicating relative service utilisation and reporting completeness over the quarters. Stillbirths remain significantly lower in magnitude throughout the year, though slight quarter-to-quarter fluctuations are observed. Overall, the comparison highlights performance in maternal and newborn outcomes, with particular attention to monitoring stillbirth trends as a key marker of quality of care during labour and delivery. When comparing the annual rates for 2024 with the available data for 2025 (Q1–Q3), there is a modest improvement observed and a slight decline in stillbirths in 2025 so far.

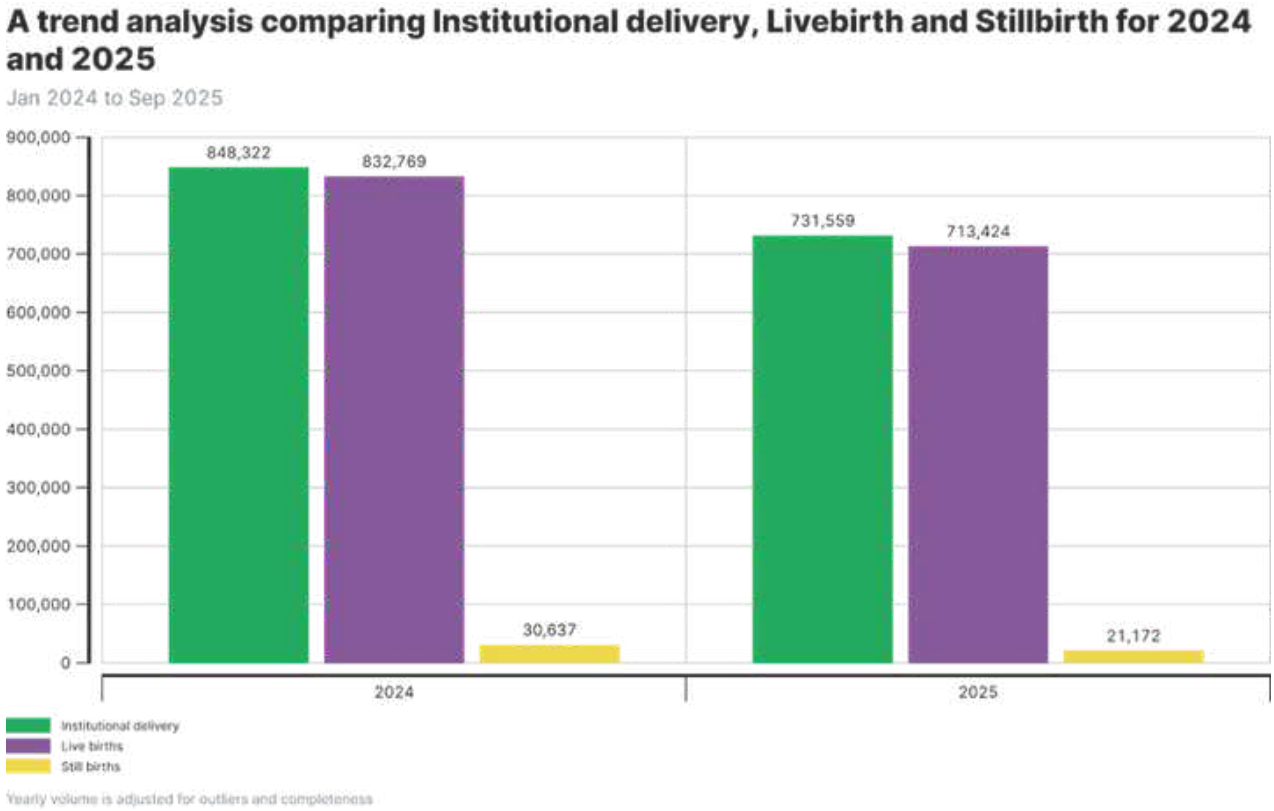


Figure 126: A trend analysis comparing institutional deliveries, livebirths and stillbirths for 2024 and 2025

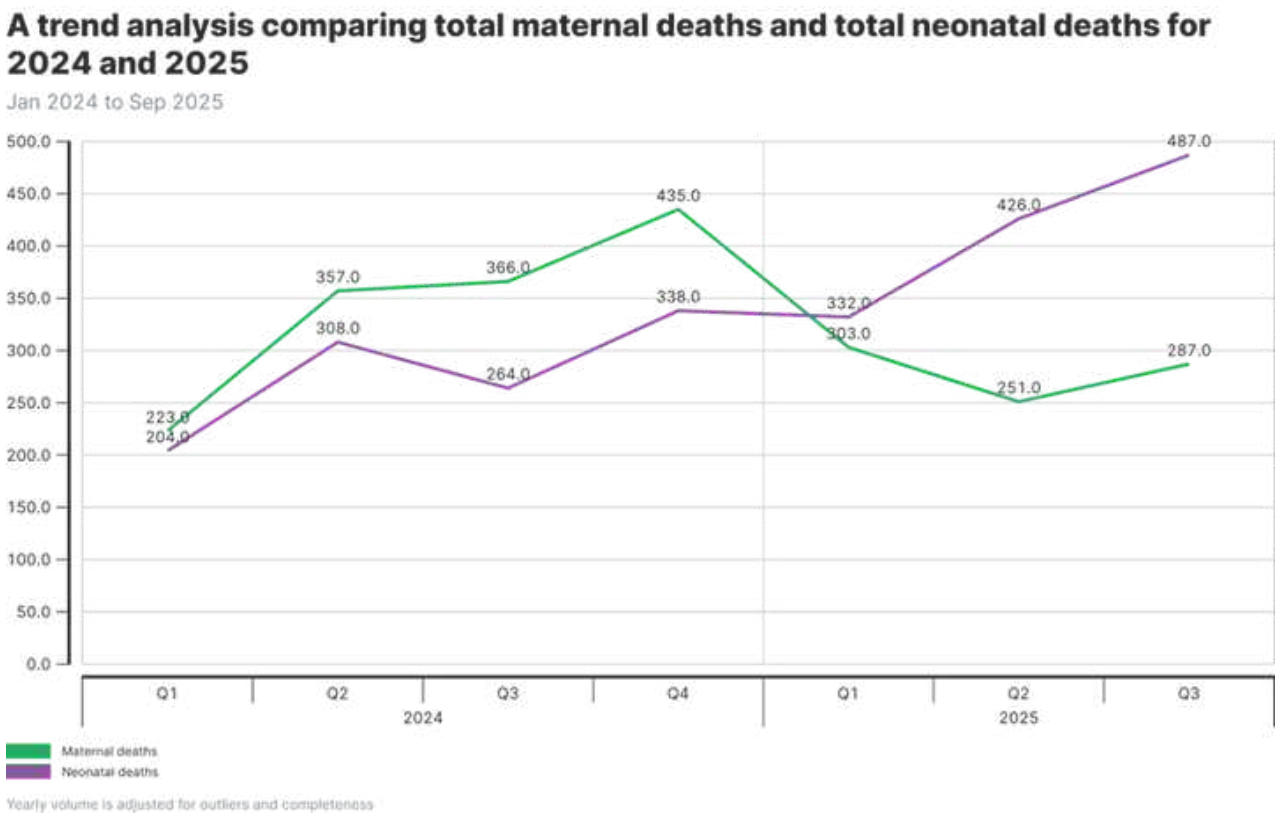


Figure 127: A trend analysis comparing total maternal deaths and Neonatal deaths for 2024 and 2025 by quarter

Achievements

The Maternal and Neonatal Mortality Reduction Innovation Initiative (MAMII) has achieved significant progress in strengthening Nigeria's health system response to maternal and neonatal mortality. 166 LGAs have developed context-specific costed work plans using the national comprehensive implementation guide to improve ANC attendance, over 400,000 pregnant women have been line listed, while the number of referral (CEmONC) facilities has been increased from 66 to 231 with over 4,000 caesarean sections done at no cost to the pregnant women enrolled under the National Health Insurance programme. Lifesaving MNCH commodities have been distributed to over 500 facilities, and emergency transport systems have been activated in LGAs in 12 States. Early data show increased facility and antenatal attendance as well as skilled birth attendance. The gains made so far can be attributed to significant efforts by LGHAs, States, and the Federal teams.

Gaps

The key gaps identified include that many LGAs lack sufficient community health workers for household-level tracking and demand creation and inadequate numbers of functional designated BEmONC and CEmONC facilities. Emergency transport services are still limited in coverage, with delayed driver payments and weak digital systems. Similarly, MPCDSR implementation remains weak across facilities in the 172 LGAs, and delays in the release of funds under the States' annual Operational Plans threaten continuity.

Recommendations

To sustain the continuous reduction in maternal and newborn deaths must prioritize strengthening community health systems, scaling and digitizing emergency transport services, and ensuring full functionality of BEmONC and CEmONC facilities. Institutionalizing MPDSR and mobilizing domestic resources in a timely manner are critical to sustain impact.

With continued high-level coordination, expansion of proven interventions, and alignment with global best practices, MAMII can catalyze Nigeria's progress toward crashing preventable maternal and neonatal deaths.

Expert Panel Recommendations

A summary of recommendations made against various pillars and enablers were reviewed to ensure alignment with the NHSRII. The group of experts made up of representatives from the Ministry, Partners and the Private sector, proposed the following:

To Strengthen Leadership and Governance

A Resolutions from the NCH and SCH should be prioritized in the development of policies to drive health sector reforms at all levels of care and tiers of governance

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B Governments at all Federal, State and LGA should institute mechanisms to ensure the timely release of funds for AOPs at all levels and introduce compliance mechanisms for expenditure tracking, for both domestic and donor funds, through the RMET to facilitate accountability and efficiency of utilization of funds.

C All facilities (public and private) in-country should be assessed for minimum standards, and Certificates of Standards are to be issued to qualifying facilities in line with the provisions of the National Health Act 2014. This should include increasing nationwide access to quality, certified, emergency obstetric and newborn care (EmONC) by expanding both BEmONC and CEmONC coverage. This should include and ensuring that every CEmONC facility is linked to a functional, NBTS registered blood banks and MLSCN/IPAN registered laboratories to reduce maternal and neonatal mortality.

To Strengthen Service Delivery

A The Federal Ministry of Health and Social Welfare should deepen integrated and functional service delivery by aligning and streamlining national programmes (e.g. immunization, HIV, TB, malaria, NCD, NTD) efforts and emphasizing routine health services to optimize resource use and sustain health outcomes.

B The strengthening of health promotion in various aspects of the health sector should be prioritized especially in regard to improving governance, coordination and improved outcomes. Specifically, there should be focus on harmonized advocacy and community mobilization especially regarding improvement in 4th ANC attendance, insurance coverage and response to emergencies.

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To Strengthen Unlocking the Value Chain

A As FGON facilitates the local production of pharmaceuticals and vaccines, priority should focus on optimizing and harmonizing Supply Chain Systems by utilizing public and private sector capacity. Specifically, mapping and integration of existing supply chain systems should be undertaken especially at the Primary Health Care (PHC) level to improve efficiency, reduce stockouts, and ensure timely delivery of essential medicines.

To Strengthen Health Security

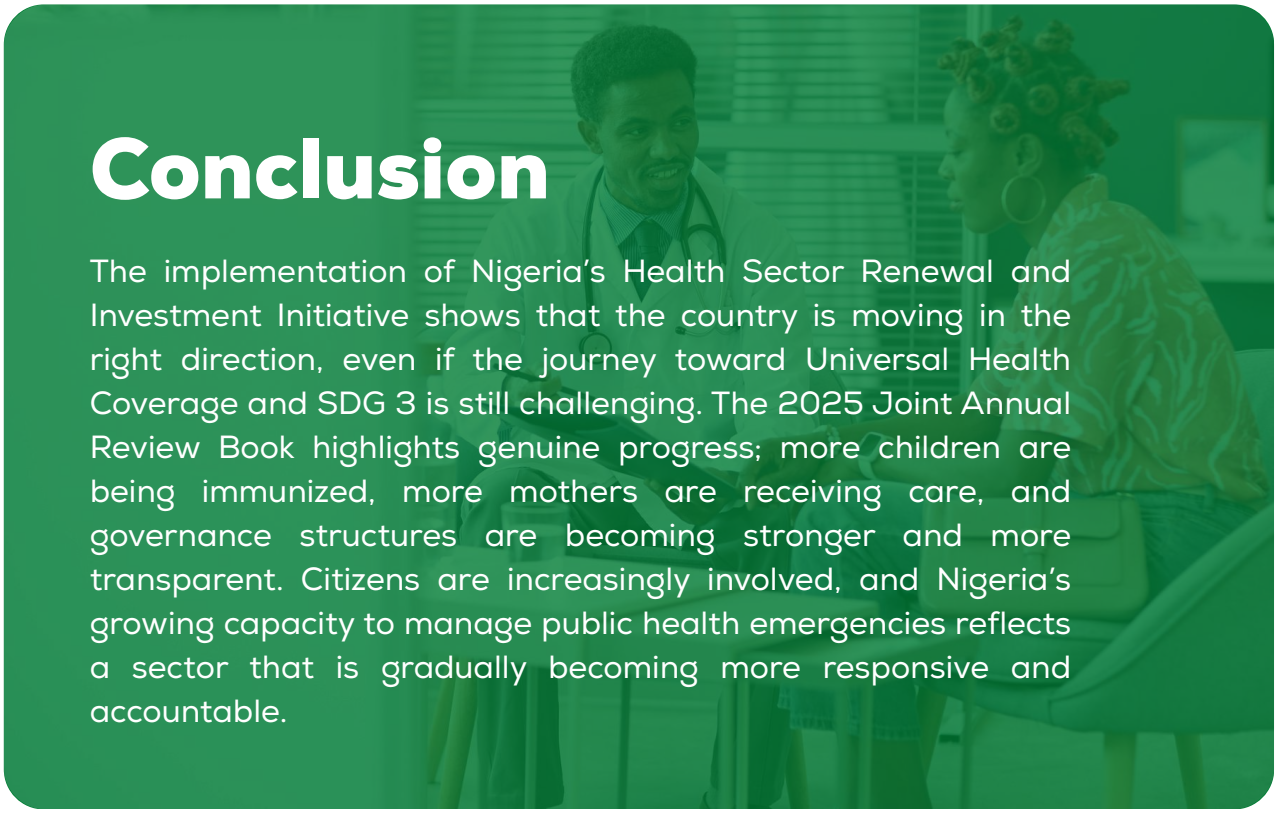
A Strengthen Health Security Governance for institutionalization of One Health approach towards effective coordination at Federal, State and LGA levels. Priorities of government should focus on the development of legal and policy frameworks for seamless integration of human, animal, and environmental health services.

B Governments at all levels should invest in sustained capacity building for a critical mass of health security personnel, including healthcare workers and allied responders, in public health emergency management, with a strong focus on climate-related emergencies, veterinary services and Anti-Microbial Resistance.

To Strengthen Enablers of Implementation of NHSRII

A Accelerate the implementation of digitization and digitalization of various aspects of the health sector by adopting global guidelines and standards. This should include accelerating the nationwide adoption of digital surveillance platforms, such as e-IDSR, an early warning system for climate-related health threats to enable real-time data reporting and seamless integration across human, animal, and environmental health systems under the One Health framework.

B In-country capability for research should be optimized, especially with regards to production of essential medicines and commodities. This may include the establishment of a Health Research and Innovation Fund, to advance progress toward Universal Health Coverage.



Conclusion

The implementation of Nigeria's Health Sector Renewal and Investment Initiative shows that the country is moving in the right direction, even if the journey toward Universal Health Coverage and SDG 3 is still challenging. The 2025 Joint Annual Review Book highlights genuine progress; more children are being immunized, more mothers are receiving care, and governance structures are becoming stronger and more transparent. Citizens are increasingly involved, and Nigeria's growing capacity to manage public health emergencies reflects a sector that is gradually becoming more responsive and accountable.

Yet, the review guide document also reminds us that these gains are not enough. Too many Nigerians still face barriers when seeking quality care, and preventable issues such as maternal deaths, malnutrition, and financial hardship continue to hold the system back. Local production of essential health products is improving, but it has not reached the scale needed to ensure national self-reliance. Challenges in regulation, health insurance coverage, and climate resilience further threaten the progress already made.

Ultimately, the Initiative has laid important groundwork, but deeper commitment and better coordination are needed to truly transform the health system. Strengthening the health workforce, improving data quality, investing in local manufacturing, and expanding financial protection will be key to accelerating progress. With consistent investment and strong political will, Nigeria has the potential not only to sustain current gains but to build a health system that genuinely meets the needs of all its people.

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